Missouri Medicaid Professional Billing Book

Missouri Department of Social Services
Division of Medical Services

Published by the Provider Education Unit

Missouri Medicaid Professional Billing Book

PREFACE

The *Professional Billing Book* contains information to help providers submit claims correctly to the Missouri Medicaid program. The information is recommended only for Missouri Medicaid providers and billers whose Medicaid provider numbers begin with 20, 24, 25, 30, 35, 36, 42, 50, 51, 52, 54, 55, 70, 71, and 91. The book is not all inclusive of program benefits and limitations. Providers should refer to specific program manuals for complete information.

SECTION 1
MEDICAID PROGRAM RESOURCES
Informational Resources available at www.dss.mo.gov/dms

CONTACTING MEDICAID

PROVIDER COMMUNICATIONS

The following phone numbers are available for Medicaid providers to call with inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, and recipient eligibility questions and verification. The (573) 635-8908 number provides an interactive voice response (IVR) system that can address recipient eligibility, last two check amounts and claim status inquiries. Providers must use a touchtone phone to access the IVR. There is no option to be transferred to the Provider Communications Unit from the IVR. See page 1.3 for more information on the IVR.

Provider Communications	(573) 751-2896
Interactive Voice Response (IVR)	(573) 635-8908

The Provider Communications Unit also processes written inquires. Written inquiries should be sent to:

Provider Communications Unit
Division of Medical Services
PO Box 6500
Jefferson City, Missouri 65102

INFOCROSSING HEALTHCARE SERVICES, INC. HELP DESK

(573) 635-3559

Call this number for assistance in establishing the required electronic claims and remittance advice formats, network communication, HIPAA trading partner agreements and assistance with the Infocrossing Internet billing service.

PROVIDER ENROLLMENT

Providers can contact Provider Enrollment via E-mail as follows for questions regarding enrollment applications: providerenrollment@dss.mo.gov.

Changes regarding address, ownership, tax identification number, name (provider or practice), or Medicare number must be submitted in writing to:

Provider Enrollment Unit
Division of Medical Services
PO Box 6500
Jefferson City, Missouri 65102

THIRD PARTY LIABILITY
(573) 751-2005
Call the Third Party Liability Unit to report injuries sustained by Medicaid recipients, problems obtaining a response from an insurance carrier, or unusual situations concerning third party insurance coverage for a Medicaid recipient.

PROVIDER EDUCATION
(573) 751-6683
Provider Education Unit staff are available to educate providers and other groups on proper billing methods and procedures for Medicaid claims. Contact the Unit for training information and scheduling.

RECIPIENT SERVICES
(800) 392-2161 or (573) 751-6527
The Recipient Services Unit assists recipients regarding access to providers, eligibility, covered and non-covered services and unpaid medical bills.

MEDICAID EXCEPTIONS AND DRUG PRIOR AUTHORIZATION HOTLINE
(800) 392-8030
Providers can call this toll free number to initiate an emergency request for an essential medical service or an item of equipment that would not normally be covered under the Medicaid program, or to request a drug prior authorization. The Medicaid exceptions fax line for non-emergency requests only is (573) 522-3061; the fax line to obtain a drug prior authorization is (573) 636-6470.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) INFORMATION

Billing providers who want to exchange electronic information transactions with Missouri Medicaid can access the *HIPAA-EDI Companion Guide* online by going to the Division of Medical Services Web page at www.dss.mo.gov/dms and clicking on the “Providers” link at the top of the page. On the Provider Participation page, click on the HIPAA-EDI Companion Guide link in the column on the left hand side of the page. This will take you directly to the EDI Companion Guide and X12N Version 4010A1 Companion Guide links.

For information on the Missouri Medicaid Trading Partner Agreement, click on the link to Section 1- Getting Started, then select Trading Partner Registration.

All questions concerning the Trading Partner Agreement or provider testing schedules are to be directed to the Infocrossing Healthcare Services Help Desk, (573) 635-3559.

INTERACTIVE VOICE RESPONSE (IVR)
(573) 635-8908

The Provider Communications Unit Interactive Voice Response (IVR) system, (573) 635-8908, requires a touchtone phone. The nine-digit Medicaid provider number **must** be entered each time any of the IVR options are accessed. Callers are limited to ten inquiries per call on any of the options. Providers whose numbers are inactive may utilize the IVR only for dates of service during their active status.

Option 1 — Recipient Eligibility

Recipient eligibility **must** be verified **each** time a recipient presents and should be verified **prior** to the service. Eligibility information can be obtained by a recipient's Medicaid number (DCN), social security number and date of birth, or if a newborn, using the mother's Medicaid number and the baby's date of birth. Callers cannot inquire on dates that exceed one year prior to the current date. Callers will be given a confirmation number and this number should be kept as proof of the information received.

Option 2 — Last Two Check Amounts

Using this option, the caller will be given the last two Remittance Advice (RA) dates, RA numbers, and check amounts.

Option 3 — Claim Status

After entering the recipient's Medicaid number (DCN) and the date of service, the caller will be provided the status of the most current claim in the system containing the date of service entered. The caller will be told whether the claim is paid, denied, approved to pay or is being processed. In addition, the system will give the amount paid, the RA date and the Internal Control Number (ICN).

INTERNET SERVICES FOR MEDICAID PROVIDERS

The Division of Medical Services (DMS), in cooperation with Infocrossing Healthcare Services, has an Internet service for Missouri Medicaid providers. Missouri Medicaid providers have the ability to:

- Submit claims and receive claim confirmation files;
- Verify recipient eligibility;
- Obtain remittance advices (RAs);
- Submit adjustments;
- Submit attachments;
- View claim, attachment and prior authorization (PA) status; and
- View and download public files.

The Web site address for this service is www.emomed.com. Without proper authorization, providers are unable to access the site. Only providers who are approved to be electronic billers can enroll and utilize the Web site services. To participate in the service, the provider must apply on-line at www.dss.mo.gov/dms/providers.htm. Each user is required to complete this on-line application in order to obtain a user ID and password. The application process only takes a few minutes and provides the applicant with a real-time confirmation response, user ID and password. Once the user ID and password have been received, the user can begin using the www.emomed.com Web site. The password can be changed to one of the user's own choice.

Questions regarding the completion of the on-line Internet application should be directed to the Infocrossing Healthcare Services Help Desk, (573) 635-3559.

An authorization is required for each individual person within a provider's office or a billing service who will be accessing the Internet site.

This Web site, www.emomed.com, allows for the submission of the following HIPAA compliant transactions:

837 Institutional Claims	Batched or Individual
837 Professional Claims	Batched or Individual
837 Dental Claims	Batched or Individual
270 Eligibility Inquiry	Batched or Individual
276 Claim Status Inquiry	Batched or Individual

The following standard responses are generated:

835 Remittance Advice	Batch or Printable RA
271 Eligibility Response	Batch or Individual
277 Claim Status Response	Batch or Individual

Users also have access to provider check amounts and the Claims Processing Schedule for the current fiscal year.

There is no cost for this service except for the cost of an Internet service provider access to the Internet. Additionally, there are no special software requirements. However, the user (provider) must have the proper Web browser. The provider must have one of the following Web browsers: Internet Explorer 5.0 or higher or Netscape 4.7 or higher. The Internet site is available 24 hours a day, 7 days a week with the exception of being down for scheduled maintenance.

VERIFYING RECIPIENT ELIGIBILITY THROUGH THE INTERNET

Providers can access Missouri Medicaid recipient eligibility files via the Web site. Functions include eligibility verification by recipient ID, casehead ID and child's date of birth, or Social Security number and date of birth. Eligibility verification can be performed on an individual basis or in a batch file. Individual eligibility verification occurs in real-time basis similar to the Interactive Voice Response System, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

A batch eligibility confirmation file can either be downloaded for viewing purposes or to be printed.

MEDICAID CLAIMS SUBMISSION THROUGH THE INTERNET

The following claim types, as defined by HIPAA Transaction and Code Set regulations, can be used for Internet claim submissions:

- 837 - Health Care Claim
  - Professional
  - Dental
  - Institutional (hospital inpatient and outpatient, nursing home, and home health care)
- Pharmacy (NCPDP)

The field requirements and filing instructions are similar to those for paper claim submissions. For the provider's convenience, some of the claim input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

A batch claim confirmation file can either be downloaded for viewing purposes or to be printed.

Note – Currently, some claims cannot be submitted electronically if an attachment is required unless the attachment is one of the following that can be submitted via the Infocrossing Internet Web service: Sterilization Consent, Second Surgical Opinion,

Acknowledgement of Receipt of Hysterectomy Information, or the PI-118 Referral (Lock-In) forms.

OBTAINING A REMITTANCE ADVICE THROUGH THE INTERNET

The Medicaid program phased out the mailing of paper Remittance Advices (RAs). Providers no longer receive both paper and electronic RAs. If the provider or the provider's billing service currently receives an electronic RA, (either via the emomed.com Internet Web site or other method), paper copies of the RA were discontinued. All providers and billers must have Internet access to obtain the printable electronic RA via the Infocrossing Internet Service, emomed.com.

Receiving the Remittance Advice via the Internet is beneficial to the provider or biller's operation. With the Internet RA, a user can:

- Retrieve the RA the Monday following the weekend claim processing cycle (two weeks earlier than receipt of the paper RA);
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from the desktop; and,
- Download the RA into the provider or biller's operating system for retrieval at a later date.

The Internet RA is viewable and printable in a ready to use format. Just point and click to print the RA or save it to the computer system for printing at the user's convenience.

To sign up for this service, see the instructions at the beginning of this information on Internet services. If a provider does not have access to the Internet, contact the Infocrossing Help Desk, (573) 635-3559, to learn how to obtain a paper remittance.

ADJUSTMENTS THROUGH THE INTERNET

Providers have options on the Internet Medical, Dental, Inpatient, Outpatient and Nursing Home claims for a "Frequency Code" that will allow either a 7 – Replacement (Adjustment) or an 8 – Void (Credit). This will control an individual adjustment or void, but not group adjustments or voids. Claim adjustments and credits can be submitted by utilizing the CLM, field CLMO5-3, segment of the 837 Health Care Claim.

RECEIVE PUBLIC FILES THROUGH THE INTERNET

Several public files are available for viewing or downloading from the Web site including the claims processing schedule for the State fiscal year which begins July 1 and ends June 30. Providers also have access to a listing of the HIPAA related claim codes and other HIPAA related codes.

SUBMIT ATTACHMENTS AND FORMS THROUGH THE INTERNET

Providers can submit required attachments and forms via the Internet as an option to mailing paper versions to Medicaid. A paper copy of any attachment or form submitted via the Internet must be kept with the patient's record. The following forms can be submitted through the Infocrossing Internet service.

Sterilization Consent,
Second Surgical Opinion,
PI 118 Referral (administrative lock-in), and,
Acknowledgment of Receipt of Hysterectomy Information

MISSOURI MEDICAID PROVIDER MANUALS AND BULLETINS ON-LINE
www.dss.mo.gov/dms

Missouri Medicaid provider manuals are available on-line at the DMS Web site, www.dss.mo.gov/dms. To access the provider manuals, click on the “Providers” link at the top of the DMS home page. Scroll to the bottom of the Provider Participation page and click on the "Provider Manuals" link. The next page displays an alphabetical listing of all Medicaid provider manuals. To print a manual or a section of a manual, click on the "Synchronize Contents" link on the left hand side of the page, this will bring you to the “Print a Manual” link. Instructions for printing manuals or sections of manuals are available through this link.

Missouri Medicaid provider bulletins are also available at the DMS Web site. The bulletins are published to notify providers of new program and policy changes or to clarify existing policy. To access the bulletins, click on the Provider Bulletin link on the Provider Participation page. The bulletins appear on-line at this location until the provider manuals are updated with the information contained in the bulletins. Once the manuals are updated, the bulletins are moved to the Archived Bulletin location.

CLAIMS PROCESSING SCHEDULE FOR STATE FISCAL YEAR 2007

Cycle Run/Remittance Date* -	Check Date -
Friday, June 23, 2006	Wednesday, July 5, 2006
Friday, July 7, 2006	Thursday, July 20, 2006
Friday, July 21, 2006	Monday, August 7, 2006
Friday, August 4, 2006	Monday, August 21, 2006
Friday, August 18, 2005	Tuesday, September 5, 2006
Friday, September 8, 2006	Wednesday, September 20, 2006
Friday, September 22, 2006	Thursday, October 5, 2006
Friday, October 6, 2006	Friday, October 20, 2006
Friday, October 20, 2006	Monday, November 6, 2006
Friday, November 3, 2006	Monday, November 20, 2006
Friday, November 17, 2006	Tuesday, December 5, 2006
Friday, December 8 2006	Wednesday, December 20, 2006
Friday, December 22, 2006	Friday, January 5, 2007
Friday, January 5, 2007	Monday, January 22, 2007
Friday, January 19, 2007	Monday, February 5, 2007
Friday, February 9, 2007	Tuesday, February 20, 2007
Friday, February 23, 2007	Monday, March 5, 2007
Friday, March 9, 2007	Tuesday, March 20, 2007
Friday, March 23, 2007	Thursday, April 5, 2007
Friday, April 6, 2007	Friday, April 20, 2007
Friday, April 20, 2007	Tuesday, May 8, 2007
Friday, May 4, 2007	Monday, May 21, 2007
Friday, May 18, 2007	Tuesday, June 5, 2007
Friday, June 8, 2007	Wednesday, June 20, 2007

*The Cycle Run Dates are tentative dates calculated by the Division of Medical Services. The dates are subject to change without prior notification.

*All claims submitted electronically to Infocrossing, must be received by 5:00 p.m. of the Cycle Run/Remittance Advice date in order to pay on the corresponding check date.

State Holidays

July 4, 2006 Independence Day
September 4, 2006 Labor Day
October 9, 2006 Columbus Day
November 10, 2006 Veteran's Day
November 23, 2006 Thanksgiving
December 25, 2006 Christmas

January 1, 2007 New Year's Day
January 15, 2007 Martin Luther King Day
February 12, 2007 Lincoln's Birthday
February 19, 2007 Washington's Birthday
May 7, 2007 Truman's Birthday
May 28, 2007 Memorial Day

SECTION 2
CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. Medicaid paper claims should be mailed to:

Infocrossing Healthcare Services, Inc.
P.O. Box 5600
Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3 of the Medicaid *Providers Manual* available at **www.dss.mo.gov/dms**.

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

Field number and name		Instructions for completion
1.	Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed, check the Medicare box, if a Medicaid claim is being filed, check the Medicaid box and if the patient has both Medicare and Medicaid, check both boxes.
1a.*	Insured's I.D.	Enter the patient's eight-digit Medicaid or MC+ ID number (DCN) as shown on the patient's ID card.
2.*	Patient's Name	Enter last name, first name, middle initial *in this order* as it appears on the ID card.
3.	Patient's Birth Date Sex	Enter month, day, and year of birth. Mark appropriate box.
4.**	Insured's Name	If there is individual or group insurance besides Medicaid, enter the name of the primary policyholder. If this field is completed, also complete fields 6, 7, 11, and 13. If no private insurance is involved, leave blank.
5.	Patient's Address	Enter address and telephone number if available.

Field number and name		Instructions for completion
6.**	Patient's Relationship to Insured	Mark appropriate box if there is other insurance. If no private insurance is involved, leave blank.
7.**	Insured's Address	Enter the primary policyholder's address; enter policy-holder's telephone number, if available. If no private insurance is involved, leave blank.
8.	Patient Status	Not required.
9.**	Other Insured's Name	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. If no private insurance is involved, leave blank. [See Note (1)]
9a.**	Other Insured's Policy or Group Number	Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. If no private insurance is involved, leave blank. [See Note (1)]
9b.**	Other Insured's Date of Birth	Enter the secondary policyholder's date of birth and mark the appropriate box reflecting the sex of the secondary policyholder. If no private insurance is involved, leave blank. [See Note (1)]
9c.**	Employer's Name	Enter the secondary policyholder's employer's name. If no private insurance is involved, leave blank. [See Note (1)]
9d.**	Insurance Plan	Enter the secondary policyholder's insurance plan name. If no private insurance is involved, leave blank. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* [See Note (1)]

Field number and name	Instructions for completion
10a.-10c.** Is Condition Related to:	If services on the claim are related to patient's employment, an auto accident or other accident, mark the appropriate box. *If the services are not related to an accident, leave blank.* [See Note (1)]
10d. Reserved for Local Use	May be used for comments/descriptions.
11.** Insured's Policy or Group Number	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. If no private insurance is involved, leave blank. [See Note (1)]
11a.** Insured's Date of Birth	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. If no private insurance is involved, leave blank. [See Note (1)]
11b.** Employer's Name	Enter the primary policyholder's employer name. If no private insurance is involved, leave blank. [See Note (1)]
11c.** Insurance Plan Name	Enter the primary policyholder's insurance plan name. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* [See Note (1)]
11d.** Other Health Plan	Indicate whether the patient has a secondary health insurance plan. If so, complete fields 9-9d with the secondary insurance information. [See Note (1)]
12. Patient's Signature	Leave blank.
13. Insured's Signature	This field should be completed only when the patient has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the

Field number and name		Instructions for completion
		provider of Medicaid. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.
14.**	Date of Current Illness, Injury or Pregnancy	This field is required when billing global prenatal and delivery services. The date should reflect the last menstrual period (LMP).
15.	Date Same/Similar Illness	Leave blank.
16.	Dates Patient Unable to Work	Leave blank.
17.**	Name of Referring Physician or Other Source	Enter the name of the referring physician. If the physician is nonparticipating in the Missouri Medicaid Program, enter "nonparticipating." *This field is required for independent laboratories and independent radiology groups (provider types 70 and 71), and providers with a specialty of "30" (radiology/radiation therapy).*
17a.**	I.D. Number of Referring Physician	Enter the referring physician's Medicaid provider number. If the physician is nonparticipating in the Missouri Medicaid Program, enter "nonparticipating." *This field is required for independent laboratories and independent radiology groups (provider types 70 and 71), and providers with a specialty of "30" (radiology/radiation therapy).*
18.**	Hospitalization Dates	If the services on the claim were provided in an in-patient hospital setting, enter the admit and discharge dates. If the patient is still in the hospital at the time of filing, write "still" in the discharge date field or show the last date of in-patient service that is being billed in field 24a. This field is required when the service is performed on an in-patient basis.
19.	Reserved for Local Use	Providers may use this field for additional remarks/descriptions.

Field number and name	Instructions for completion
20.** Lab Work Performed Outside Office	If billing for laboratory charges, mark the appropriate box. The referring physician may **not** bill for lab work that was referred out.
21.* Diagnosis	Enter the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis as No. 1, the secondary diagnosis as No. 2, etc.
22.** Medicaid Resubmission	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.
23. Prior Authorization Number	Leave blank**.**
24a.* Date of Service	Enter the date of service under "from" in month/day/year format, using a six-digit format. All line items **must** have a from date. A "to" date of service is required when billing on a single line for subsequent physician hospital visits on consecutive days.
24b.* Place of Service	Enter the appropriate place of service code. See Section 15.8 of the Medicaid *Physician's Provider Manual* for the list of appropriate place of service codes.
24c. Type of Service	Leave blank.
24d.* Procedure Code	Enter the appropriate CPT or HCPCS code and applicable modifier(s), if any, corresponding to the service rendered. (Field 19 may be used for remarks or descriptions.) See Section 6 of this booklet for a list of modifiers used by the Missouri Medicaid program.
24e.* Diagnosis Code	Enter 1, 2, 3, 4 or the actual diagnosis code(s) from field 21.

Field number and name	Instructions for completion
24f.* Charges	Enter the provider's usual and customary charge for each line item. This should be the total charge if multiple days or units are shown.
24g.* Days or Units	Enter the number of days or units of service provided for each detail line. The system automatically plugs a "1" if the field is left blank. Anesthesia—Enter the total number of minutes of anesthesia. Consecutive visits—Subsequent hospital visits may be billed on one line if they occur on consecutive days. The days/units must reflect the total number of days shown in field 24a. Injections—Only for those providers not billing on the Pharmacy Claim form. Enter multiple increments of the listed quantity administered. For example, if the listed quantity on the injection list is 2 cc and 4 cc are given, the quantity listed in this field is "2."
24h.** EPSDT/Family Planning	If the service is an EPSDT/HCY screening service or referral, enter "E." If the service is family planning related, enter "FP." If the service is both an EPSDT/HCY and Family Planning service enter "B."
24i. Emergency	Leave blank.
24j. COB	Leave blank.
24k.** Performing Provider Number	This field is required only for a clinic (group practice), FQHC, public health agency, teaching institution or independent radiology group. Enter the Missouri Medicaid provider number of the physician or other professional who performed the service.
25. SS#/Fed. Tax ID	Leave blank.
26. Patient Account Number	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here.
27. Assignment	Not required on Medicaid claims.

Field number and name		Instructions for completion
28.*	Total Charge	Enter the sum of the line item charges.
29.**	Amount Paid	Enter the total amount received by all other insurance resources. **Previous Medicaid payments, Medicare payments, cost sharing and co-pay amounts are not to be entered in this field.**
30.	Balance Due	Enter the difference between the total charge (field 28) and the insurance amount paid (field 29).
31.	Provider Signature	Not Required.
32.**	Name and Address of Facility	If the services were rendered in a facility other than the home or office, enter the name and location of the facility. This field is required when the place of service is other than home or office.
33.*	Provider Name/ Number /Address	Affix the provider label or write or type the information **exactly** as it appears on the label.

* These fields are mandatory on all CMS-1500 claim form.

** These fields are mandatory only in specific situations, as described.

(1) NOTE: This field is for private insurance information only. If no private insurance is involved **leave blank**. If Medicare, Medicaid, employers name or other information appears in this field, the claim will deny. See Section 5 of the Medicaid *Provider's Manual* for further TPL (Third Party Liability) information.

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

SECTION 3
INJECTION (PHARMACY) CLAIM FILING INSTRUCTIONS

Effective July 1, 2005, all pharmacy claims, except for adjustments, must be submitted electronically either through a clearinghouse, billing agent or the Medicaid website at www.emomed.com for billing and to maintain the business relationship with the Division of Medical Services. Additional information regarding pharmacy claims was published in a Medicaid Pharmacy Bulletin dated July 29, 2005.

MEDICATION BILLING

The quantity to be billed for injectable medications dispensed to Missouri Medicaid recipients must be calculated as follows:

- Containers of medication in solution (for example, ampules, bags, bottles, vials, syringes) must be billed by the exact cubic centimeters or milliliters (cc or ml), even if the quantity includes a decimal (i.e., if three (3) 0.5 ml vials are dispensed, the correct quantity to bill would be 1.5 mls).
- Single dose syringes and single dose vials must be billed per cubic centimeters or milliliters (cc or ml), rather than per syringe or per vial.
- Powder filled vials and syringes that require reconstitution must be billed by the number of vials.
- The product Herceptin, by Genentech, must be billed by milligram (mg) rather than by vial.
- Immunizations and vaccines must be billed by the cubic centimeters or milliliters (cc or ml) dispensed, rather than per dose.

Claims billed incorrectly are identified through a dispute resolution process. When these claims are identified, providers are notified and required to file adjustments to accurately reflect the quantity dispensed.

For specific questions concerning injectable medication billing, contact the Pharmacy Administration Unit at (573) 751-6963.

State of Missouri Medicaid

Hipaa Pharmacy Claim

If you are not [redacted] please logout Logout

User: [redacted] Provider: [redacted]

Patient Name (Last Name, First Name) *	Patient's ID *
Patient Location: 0=Not specified	Prior Authorization Type Code: 0=Not specified
Other Coverage Code: 0=Not Specified	
Prescription Number *	Prescribing Physician Medicaid Number *
Date Dispensed (mm/dd/yy) *	National Drug Code *
Fill Number *	Compound Indicator
Metric Quantity (9999999.999) *	Days Supply *
Unit Dose Indicator: 0=Not Specified	Total Charge * $
Other Coverage Amount $	Prior Authorization Number

Submit Reset

[Home] [Help]

Electronic Pharmacy Claim Form Filing Instructions

NOTE: * These fields are required on all Pharmacy claim submissions.
** These fields are required only in specific situations, as described below.

FIELD	DESCRIPTION
*Patient's Last Name	Enter the patient's full last name as shown on Medicaid ID card.
*First Name	Enter the first letter of the patient's first name as shown on the Medicaid ID card.
*Patient's ID	Enter the patient's eight digit Medicaid or MC + identification number (DCN) as shown on the patient's ID card.
Patient Location (NOTE: For pharmacy providers **only.)	Code identifying the location of the patient when receiving pharmacy services. The valid values are: 0 Not Specified 1 Home 2 Inter-Care 3 Nursing Home 4 Long Term/Extended Care 5 Rest Home 6 Boarding Home 7 Skilled Nursing Facility 8 Sub Acute Care Facility 9 Acute Care Facility 10 Outpatient 11 Hospice
**Prior Authorization Type Code.	The valid values are: 0 Not Specified 1 Prior Authorization 2 Medical Certification 3 EPSDT 4 Exemption from Copay 5 Exemption from Prescription 6 Family Plan 7 AFDC 8 Payer Defined Exemption

**Other Coverage Code

Indicate whether the patient has a secondary health insurance plan. If so, choose the appropriate value. The valid values are:

0 Not Specified
1 No Other Coverage identified
2 Other Coverage Exists – Payment Collected
3 Other Coverage Exists – This Claim Not Covered
4 Other Coverage Exists – Payment Not Collected
5 Managed Care Plan Denial
6 Other Coverage Denied – Not a Participating Provider
7 Other Coverage Exists – Not in Effect at Time of Service
8 Claim is a billing for a copay

*Prescription Number

Enter the number assigned by the pharmacy or the physician's office. Enter a sequential identification number in this field. If the billing provider chooses to use a patient account number, an additional unique identifying character must be added to identify different injections administered on the same date of service. (NOTE: This number is used to sort claims submitted electronically on the remittance advice.)

**Prescribing Physician's Medicaid Number

Enter the prescribing provider's Medicaid number or DEA number. If the prescribing provider is not a Missouri Medicaid provider, enter the prescribing provider's DEA number.

*Date Dispensed

Enter the date the drug was dispensed or administered in MM/DD/YY numeric format.

*National Drug Code

Enter the precise National Drug Code (NDC) assigned to the product dispensed or administered as it appears on the package. Always enter the entire number, separated, using the dotted lines to indicate where the hyphens appear, using the 5-4-2 format. If the drug code on the package is not in 5-4-2 format, enter zeroes in front of the numbers listed for each field. For example: NDC 45-143-20 is listed as 00045-0143-20.

*Fill Number

The code indicating whether the prescription is an

	original or a refill. Enter a two-digit value. 00 = Original dispensing, 01-99 = Refill number
**Compound Indicator	If billing for a compound drug, the first ingredient of a compound must be billed with a compound indicator of "0". All other ingredients must be billed with a compound indicator of "2". Otherwise, leave blank.
*Metric Quantity	Enter the metric quantity dispensed or used in administration, as follows: Number of tablets dispensed. Number of grams for ointments or powders. Number of cc's (ml's) administered for products in solution (ampule, I.V. bag, bottle, syringe, vial). Number of vials used containing powder for reconstitution. Immunizations and vaccines must be billed by the cubic centimeters or milliliters (cc or ml) dispensed. Implant (1 kit = 1 unit).
*Days supply	Enter the estimated duration of the prescription supply in days. If it is a PRN medication, use 77. **If billing for administration at a physician's office, the value should always equal 1.**
Unit Dose Indicator	Indicate the type of unit dose dispensing. The valid values are: 0 Not Specified 1 Not Unit Dose 2 Manufacturer Unit Dose 3 Pharmacy Unit Dose
*Total Charge	Enter the provider's usual and customary charge for this service.
**Other Coverage Amount	Enter the total amount received by all other insurance resources. Previous Medicaid payments, Medicare payments, cost sharing and copay amounts are **not** to be entered in this field. This field is required if the Other Coverage Code field has a value.
**Prior Authorization Number	Enter the Prior Authorization number, if applicable. Otherwise, leave blank.

SECTION 4
MEDICARE CROSSOVER CLAIMS

Medicare/Medicaid (crossover) claims that do not cross automatically from Medicare to Medicaid, must now be filed through the Medicaid billing Web site at www.emomed.com or through the 837 electronic claims transaction. This requirement became effective July 1, 2005. Before filing an electronic crossover claim, please wait sixty (60) days from the date of your Medicare payment to avoid possible duplicate payments from Medicaid.

The major reason that claims do not cross over electronically from Medicare to Medicaid is because Medicaid enrolled providers have not provided Medicaid with their Medicare provider number or have provided an invalid or inactive Medicare provider number. If the provider is enrolled with Medicare as a group/clinic, then the provider must also enroll with Medicaid as a clinic. Both the group/clinic Medicare number and each individual practioner's Medicare number must be on file with Medicaid. If the provider has more than one number with Medicare and Medicaid, be sure to provide the proper Medicare number for each specific Medicaid provider number or the claims may not cross to Medicaid electronically.

If the provider has any doubt as to what Medicare number(s) is (are) on file for the provider, contact the Provider Enrollment Unit by e-mail at providerenrollment@dss.mo.gov. If you have not submitted your provider number to Medicaid, you can fax a copy of the Medicare letter showing the Medicare provider name and Medicare number assigned along with a cover letter explaining why the information is being submitted to the enrollment unit. The unit's fax number is 573/526-2054.

Following are tips to assist you in successfully filing a claim at the Medicaid billing Web site:

- At the Medicaid billing Web site at www.emomed.com, choose the same crossover claim form that you completed to bill Medicare. For professional crossover claims, select "Medicare CMS 1500 Part B Crossover." For FQHC claims, select either "Medicare CMS 1500 Part B Crossover" or "Medicare UB-92 Part B of A Crossover" whichever is appropriate. For dialysis center claims, select "Medicare UB-92 Part B of A Crossover." Be sure you select the correct provider number from the drop down box in the upper right hand corner of the first claims screen. If you filed to Medicare under a clinic number, then you should file to Medicaid under a clinic number. If you filed to Medicare under an individual provider number, you should file to Medicaid under an individual provider number.
- There are HELP screens at the bottom of each screen page to provide instructions for completing the crossover claim screens, the "Other Payer" header

and the “Other Payer” detail screens. Print each HELP screen in its entirety for reference when completing claims on the Internet.

- Enter the information in the fields on the screen exactly as you did on your Medicare billing except that you should enter the patient’s name as it appears on the Medicaid card and **not** the name that is shown on the Medicare remittance advice.
- There must be an “Other Payer” header screen completed for every crossover claim type. This provides information that pertains to the whole claim.
- Part B and Part B of A claims need the “Other Payer” header form completed without group code, reason code and adjustment amount information. Completion of an “Other Payer” detail screen form is required for each claim detail line.
- The five (5) codes that can be entered in the "Group Code" field on the "Other Payer" Header and Detail screen forms are in a drop down box and you should choose the appropriate code. For example, the "PR" code (patient responsibility) is understood to be the code assigned for deductible and/or coinsurance amounts shown on your Medicare EOMB.
- The codes to enter in the "Reason Code" field on the "Other Payer" Header and Detail screen forms are found on your Medicare EOMB. If not listed there, you must choose the most appropriate code from the list of "Claim Adjustment Reason Codes" which can be found in the HIPAA Related Code List under the Quick Links at http://www.dss.mo.gov/dms/providers.htm. For example, the code shown on the "Claim Adjustment Reason Codes" list for "deductible amount" is 1 and for "coinsurance amount" is 2. Therefore, you would enter a "Reason Code" of "001" for deductible amounts due and a "Reason Code" of "002" for coinsurance amounts due.
- The "Adjust Amount" should reflect any amount not paid by Medicare including deductible, coinsurance, and any non-allowed amounts.
- If there is a commercial insurance payment or denial to report on the crossover claim, you must complete an additional "Other Payer" Header form. You must also complete an additional "Other Payer" Detail form(s) if the commercial carrier provided detail line information for line payments and denials.

Samples of Part B (professional) (including one with commercial insurance in addition to Medicare and Medicaid), Part B of A (FQHC) and Part B of A (dialysis) claims are displayed on the following pages.

SAMPLE MEDICARE REMITTANCE
PART B - CMS - 1500 (NO TPL)

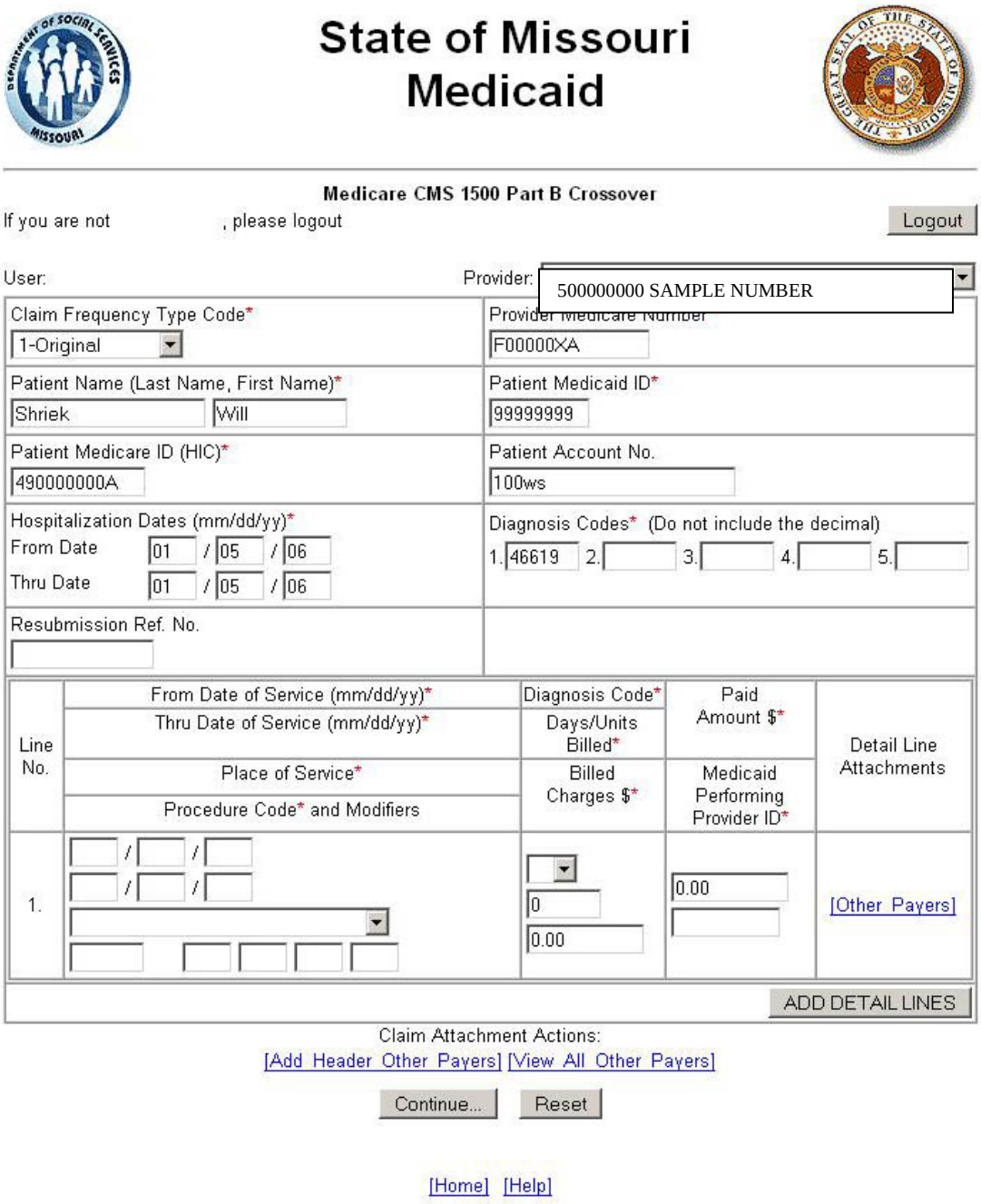
CENTRAL CLINIC
P.O. BOX 25X
JEFFERSON, MO 65107

MEDICARE
REMITTANCE
NOTICE

PROVIDER: F00000XA
PAGE #: 1 OF 1
DATE: 02/01/2006
CHECK/EFT #: 000257X
STATEMENT #: 09050007XY

PERF PROV.	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME: SHRIEK, WILL		HIC: 490000000A				ACNT: 100WS		ICN 06027000000000			
F000000A	0105 010506	21	1	99231		51.00	32.35	0.00	6.47 CO-42	18.65	25.88
PT RESP	6.47			CLAIM TOTALS		51.00	32.35	0.00	6.47	18.65	25.88
ADJ TO TOTALS: PREV PD 0.00				INTEREST:		0.00		LATE FILING CHARGE 0.00			NET 25.88

Using this example of a Medicare EOMB, the following pages will guide you step-by-step through the process to file your Crossover Claim through the Medicaid billing web site at www.emomed.com to collect the co-insurance amount.



State of Missouri
Medicaid

Medicare CMS 1500 Part B Crossover

If you are not , please logout Logout

User: Provider: 500000000 SAMPLE NUMBER

Claim Frequency Type Code* 1-Original	Provider Medicare Number F00000XA
Patient Name (Last Name, First Name)* Shriek Will	Patient Medicaid ID* 99999999
Patient Medicare ID (HIC)* 490000000A	Patient Account No. 100ws
Hospitalization Dates (mm/dd/yy)* From Date 01 / 05 / 06 Thru Date 01 / 05 / 06	Diagnosis Codes* (Do not include the decimal) 1. 46619 2. 3. 4. 5.
Resubmission Ref. No.	

Line No.	From Date of Service (mm/dd/yy)* / Thru Date of Service (mm/dd/yy)* / Place of Service* / Procedure Code* and Modifiers	Diagnosis Code* / Days/Units Billed* / Billed Charges $*	Paid Amount $* / Medicaid Performing Provider ID*	Detail Line Attachments
1.	/ / / /	0 0.00	0.00	[Other Payers]

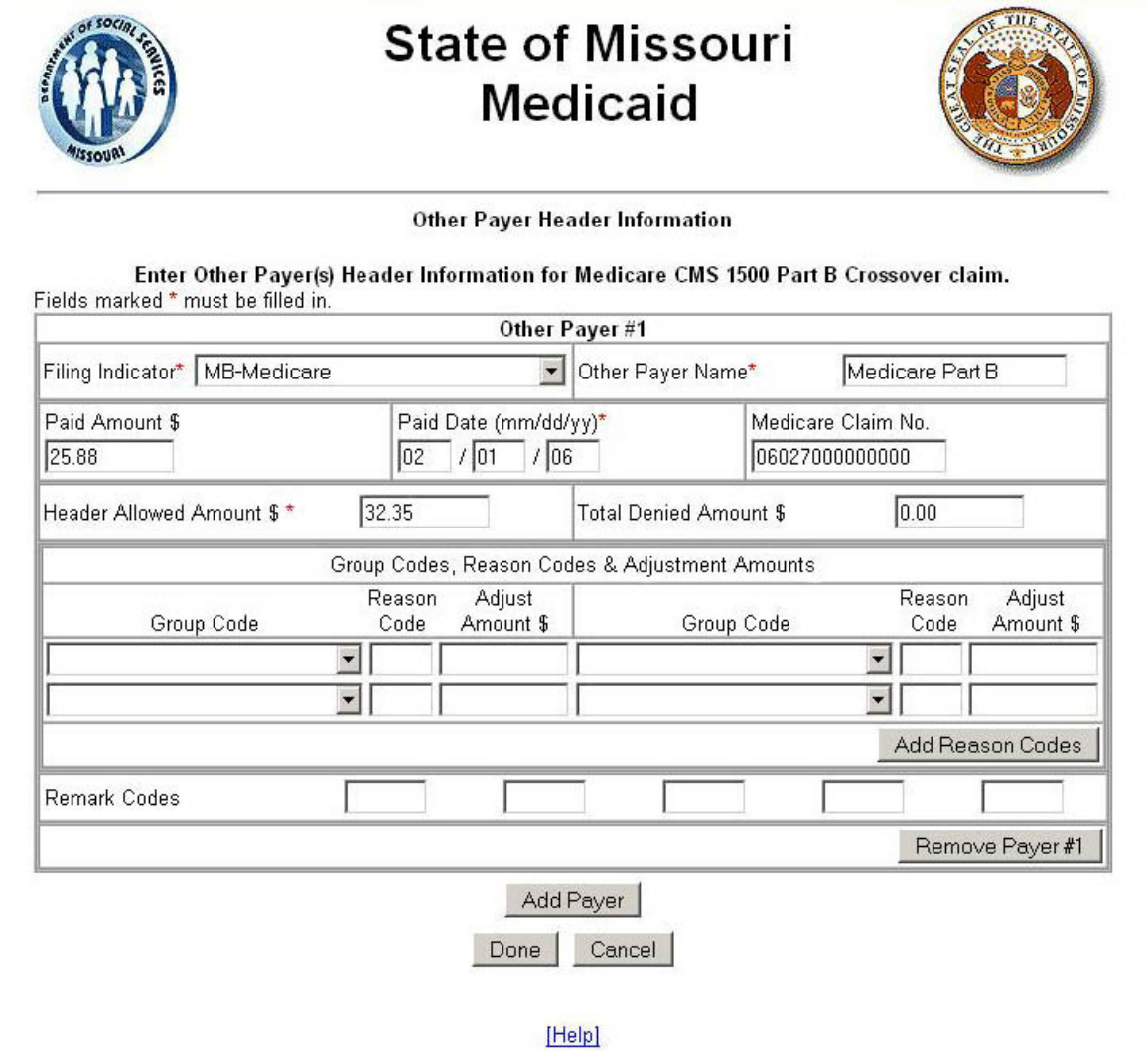
ADD DETAIL LINES

Claim Attachment Actions:
[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **At the Medicaid billing Web site, click on "Medicare CMS 1500 Part B Crossover". That will bring you to the screen above.**
- **Enter all the Medicaid header information. Refer to the Medicare EOMB on the previous page as well as the patient's medical record. Complete the fields as shown above. Then click on "Add Header Other Payers" link at the bottom of the page to enter the header other payer information.**
- **Note-if the service was not provided in the hospital, enter all zeros in the "Hospitalization Dates" fields.**



State of Missouri
Medicaid

Other Payer Header Information

Enter Other Payer(s) Header Information for Medicare CMS 1500 Part B Crossover claim.

Fields marked * must be filled in.

Other Payer #1

Filing Indicator*	MB-Medicare	Other Payer Name*	Medicare Part B
Paid Amount $	25.88	Paid Date (mm/dd/yy)*	02 / 01 / 06
Medicare Claim No.	060270000000000		
Header Allowed Amount $ *	32.35	Total Denied Amount $	0.00

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $

Add Reason Codes

Remark Codes

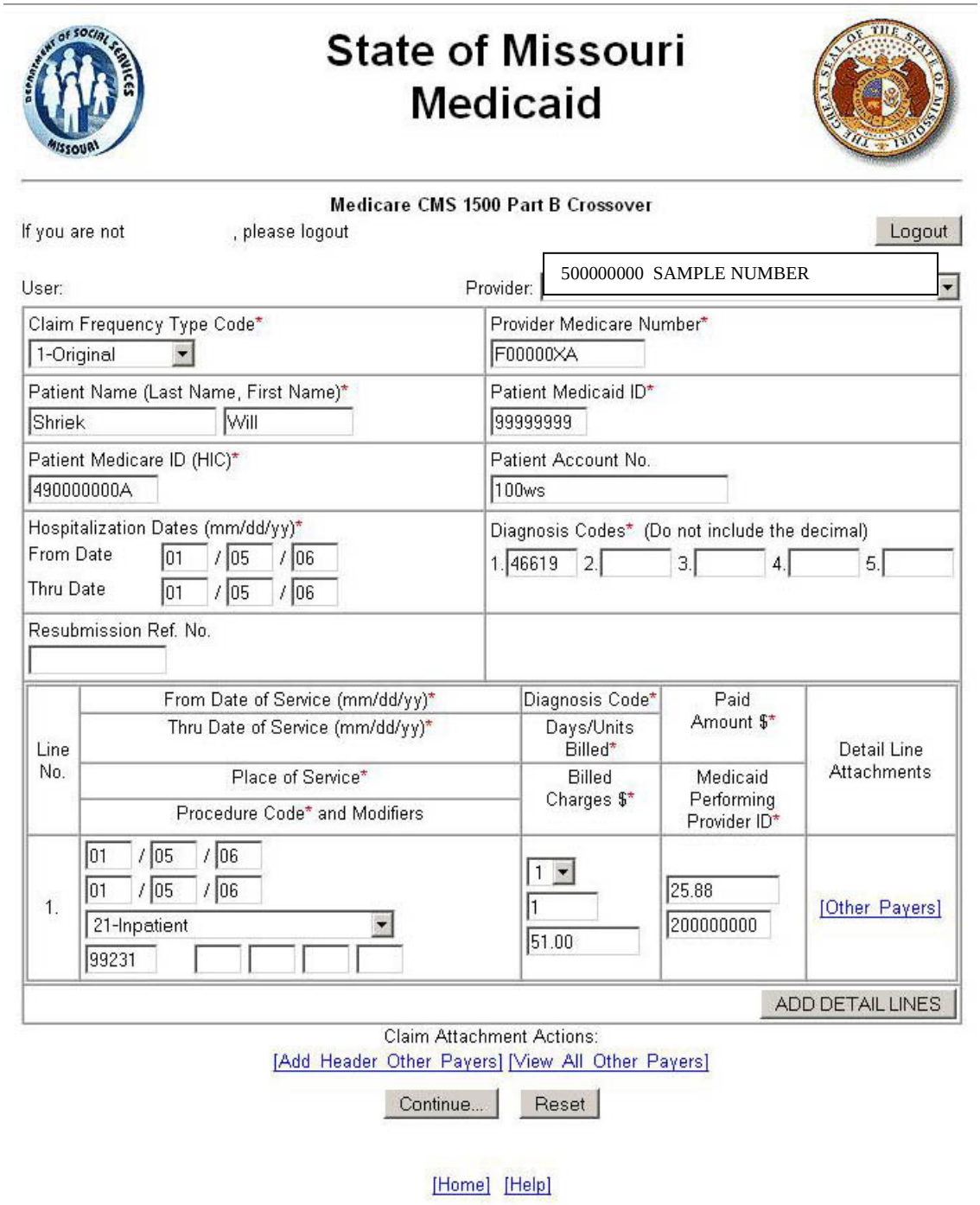
Remove Payer #1

Add Payer

Done Cancel

[Help]

- **Now you are on the "Other Payer Header" screen.**
- **Enter the information as shown. For Part B and Part B of A crossover claims, do not complete the Group Codes, Reason Codes and Adjustment Amounts information. You will be entering this information elsewhere.**
- **Click on "Done".**



State of Missouri Medicaid

Medicare CMS 1500 Part B Crossover

If you are not , please logout Logout

User: Provider: 500000000 SAMPLE NUMBER

Claim Frequency Type Code* 1-Original	Provider Medicare Number* F00000XA
Patient Name (Last Name, First Name)* Shriek Will	Patient Medicaid ID* 99999999
Patient Medicare ID (HIC)* 490000000A	Patient Account No. 100ws
Hospitalization Dates (mm/dd/yy)* From Date 01 / 05 / 06 Thru Date 01 / 05 / 06	Diagnosis Codes* (Do not include the decimal) 1. 46619 2. 3. 4. 5.
Resubmission Ref. No.	

Line No.	From Date of Service (mm/dd/yy)* / Thru Date of Service (mm/dd/yy)* / Place of Service* / Procedure Code* and Modifiers	Diagnosis Code* / Days/Units Billed* / Billed Charges $*	Paid Amount $* / Medicaid Performing Provider ID*	Detail Line Attachments
1.	01 / 05 / 06 01 / 05 / 06 21-Inpatient 99231	1 1 51.00	25.88 200000000	[Other Payers]

ADD DETAIL LINES

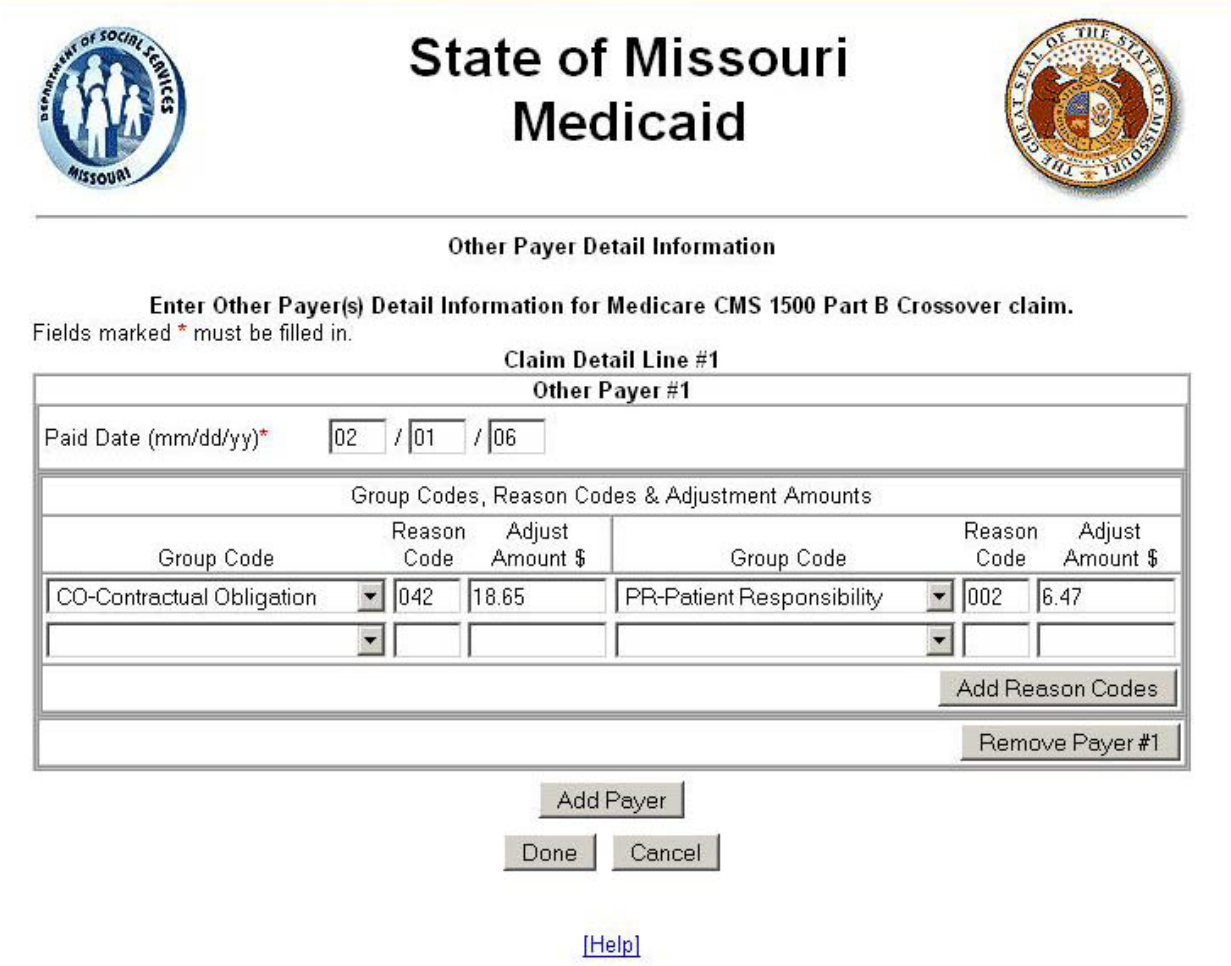
Claim Attachment Actions:

[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **Now you are back on the original screen ready to add your detail information to the claim.**
- **Again, using the Medicare EOMB example from the previous page, enter the detail information as shown above.**
- **When done entering the information, click on "Other Payers" to add the Medicare detail information.**



State of Missouri
Medicaid

Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare CMS 1500 Part B Crossover claim.
Fields marked * must be filled in.

Claim Detail Line #1

Other Payer #1

Paid Date (mm/dd/yy)* 02 / 01 / 06

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO-Contractual Obligation	042	18.65	PR-Patient Responsibility	002	6.47

Add Reason Codes

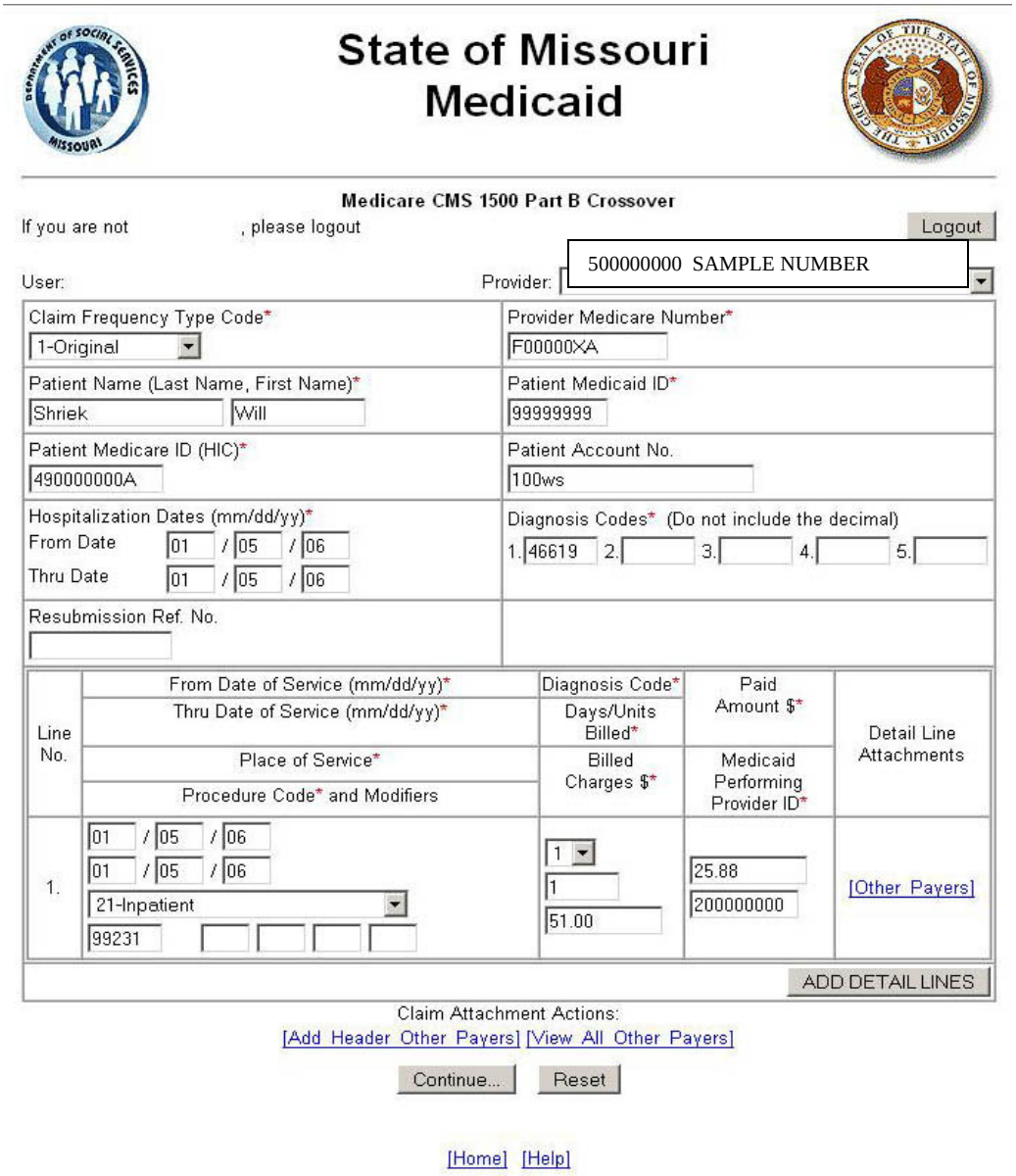
Remove Payer #1

Add Payer

Done Cancel

[Help]

- **Now you are on the "Other Payer Detail" screen.**
- **Enter the Medicare paid date information as well as the Group and Reason Codes and Adjustment Amounts. See the above sample. If the reason codes are not listed on your Medicare EOMB, choose the most appropriate code from the list of "Claim Adjustment Reason Codes" from the HIPAA Related Code List. For example, the code on the "Claim Adjustment Reason Code" list for deductible amount is 1 and for coinsurance amount is 2. Therefore, you would enter a Reason Code of 001 for deductible amounts and 002 for coinsurance amounts due.**
- **The "Adjust Amount" should reflect any amount not paid by Medicare including deductible, coinsurance and any non-allowed amounts.**
- **Click on "Done".**



State of Missouri
Medicaid

Medicare CMS 1500 Part B Crossover

If you are not , please logout Logout

User: Provider: 500000000 SAMPLE NUMBER

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: F00000XA
Patient Name (Last Name, First Name)*: Shriek, Will	Patient Medicaid ID*: 99999999
Patient Medicare ID (HIC)*: 490000000A	Patient Account No.: 100ws
Hospitalization Dates (mm/dd/yy)*: From Date 01/05/06, Thru Date 01/05/06	Diagnosis Codes* (Do not include the decimal): 1. 46619 2. 3. 4. 5.
Resubmission Ref. No.	

Line No.	From Date of Service (mm/dd/yy)* / Thru Date of Service (mm/dd/yy)* / Place of Service* / Procedure Code* and Modifiers	Diagnosis Code* / Days/Units Billed* / Billed Charges $*	Paid Amount $* / Medicaid Performing Provider ID*	Detail Line Attachments
1.	01/05/06 – 01/05/06; 21-Inpatient; 99231	1; 1; 51.00	25.88; 200000000	[Other Payers]

ADD DETAIL LINES

Claim Attachment Actions:
[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **This brings you back to the original screen. At this point, you are done entering the information. Click on "Continue".**
- **This brings you to a screen asking you to verify the information entered. You can either edit the information or submit the claim.**
- **Click on "Submit". After submitting your claim, you will be brought to a screen which states, "Thank you. Your claim has been received". Click on the "Print" button at the bottom of the screen to print off and save for your records.**
- **To enter another claim, click on "Next".**

The end.

SAMPLE MEDICARE REMITTANCE

PART B - CMS - 1500 (With Commercial Insurance)

CENTRAL
CLINIC
P.O. BOX 25X
JEFFERSON, MO 65107

MEDICARE
REMITTANCE
NOTICE

PROVIDER: F00000XA
PAGE #: 1 OF 1
DATE: 02/01/06
CHECK/EFT #: 000257X
STATEMENT #: 09050007XY

PERF PROV.	SERV DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME: SHRIEK, WILL		HIC: 490000000A			ACNT: 100WS		ICN 0602700000000			
F000000A	0106 010506	21 1	99231		51.00	32.35	0.00	6.47 CO-42	18.65	25.88
PT RESP	6.47		CLAIM TOTALS		51.00	32.35	0.00	6.47	18.65	25.88
ADJ TO TOTALS:	PREV PD 0.00		INTEREST:		0.00		LATE FILING CHARGE		0.00	NET 25.88

Using this example of a Medicare EOMB and the one on the next page for commercial insurance, the following pages will guide you step-by-step through the process to file a Medicare crossover with additional commercial insurance through the Medicaid billing Web site at www.emomed.com to collect the co-insurance amount

Please turn the page for the sample commercial EOMB.

MEDICARE PART B WITH TPL
SAMPLE TPL EOB

ABC INS.

ABC SERVICE CENTER
P.O. BOX 1111
ANYWHERE, MO 64109

DATE: 02/16/06
GROUP #: 002
GROUP NAME: CPI
CHECK NUMBER: X27445
CHECK AMOUNT: $5.18

CENTRAL CLINIC
P.O. BOX 25X
JEFFERSON CITY, MO 65107

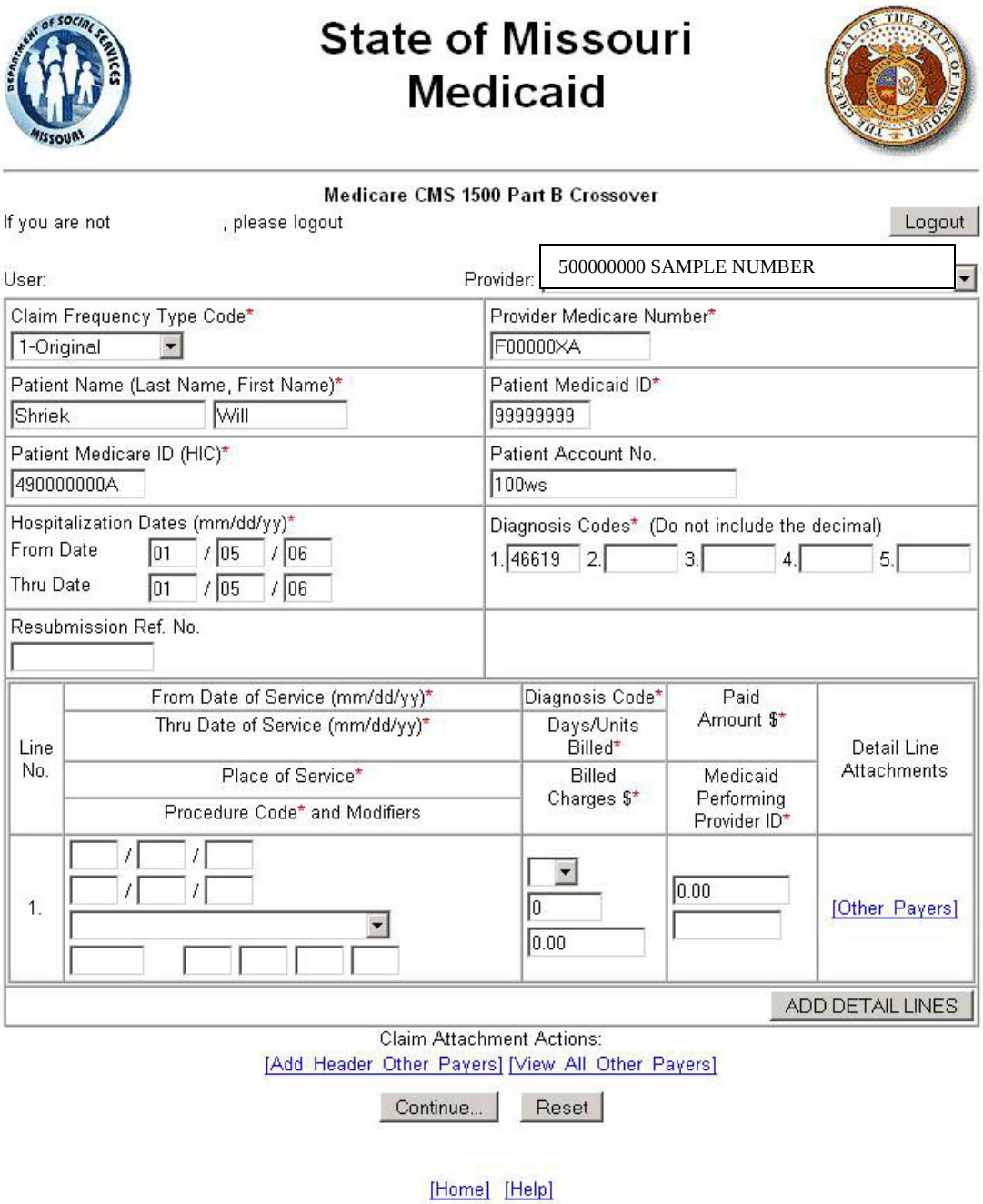
PRODUCT	MEM ID	PATIENT NAME	PATIENT ACCOUNT	MEMBER NAME	CONTROL NUMBER	DATE RECEIVED	DATE RECEIVED	PROVIDER OF SERVICE
IND	A X9974	SHRIEK, WILL	5205X	SHRIEK, WILL	61725	02/13/2006	02/13/2006	CENTRAL CLINIC

PATIENT NAME	DATES OF SERVICE	DESCRIPTION OF SERVICE	AMOUNT CHARGED	NOT COVERED	PROV ADJ DISCOUNT	AMOUNT ALLOWED	CO-INS PLAN COV	PAID TO PROVIDER	RMK CD	PATIENT RESP.
SHRIEK,WILL	01/05/06	99231	51.00			32.35	6.47 80%	5.18	PR2	1.29
		SUBTOTAL	51.00			32.35	6.47	5.18		1.29

TOTAL PAID TO PROVIDER: 5.18

This is a sample EOB for a commercial insurance that pays 80% of the patient's Medicare co-insurance.

Please turn the page to start the process for filing.



State of Missouri
Medicaid

Medicare CMS 1500 Part B Crossover

If you are not , please logout Logout

User: Provider: 500000000 SAMPLE NUMBER

Claim Frequency Type Code* 1-Original	Provider Medicare Number* F00000XA
Patient Name (Last Name, First Name)* Shriek Will	Patient Medicaid ID* 99999999
Patient Medicare ID (HIC)* 490000000A	Patient Account No. 100ws
Hospitalization Dates (mm/dd/yy)* From Date 01 / 05 / 06 Thru Date 01 / 05 / 06	Diagnosis Codes* (Do not include the decimal) 1. 46619 2. 3. 4. 5.
Resubmission Ref. No.	

Line No.	From Date of Service (mm/dd/yy)* / Thru Date of Service (mm/dd/yy)* / Place of Service* / Procedure Code* and Modifiers	Diagnosis Code* / Days/Units Billed* / Billed Charges $*	Paid Amount $* / Medicaid Performing Provider ID*	Detail Line Attachments
1.	/ / / / /	0 0.00	0.00	[Other Payers]

ADD DETAIL LINES

Claim Attachment Actions:
[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **At the Medicaid billing Web site, click on "Medicare CMS 1500 Part B Crossover". That will bring you to the screen above.**
- **Complete all the Medicaid header information. Refer to the Medicare EOMB on the previous page as well as the patient's medical record. Complete the fields as shown above then click on the "Add Header Other Payers" link at the bottom of the page to add the header other payer information.**

State of Missouri Medicaid

Other Payer Header Information

Enter Other Payer(s) Header Information for Medicare CMS 1500 Part B Crossover claim.

Fields marked * must be filled in.

Other Payer #1

Filing Indicator*	MB-Medicare	Other Payer Name*	Medicare Part B
Paid Amount $	25.88	Paid Date (mm/dd/yy)*	02 / 01 / 06
Medicare Claim No.	0602700000000		
Header Allowed Amount $ *	32.35	Total Denied Amount $	0.00

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $

Add Reason Codes

Remark Codes

Remove Payer #1

Other Payer #2

Filing Indicator*	CI-Commercial Insurance Co	Other Payer Name*	ABC Insurance
Paid Amount $	5.18	Paid Date (mm/dd/yy)*	02 / 16 / 06
Medicare Claim No.	61725		
Header Allowed Amount $ *	51.00	Total Denied Amount $	0.00

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $

Add Reason Codes

Remark Codes

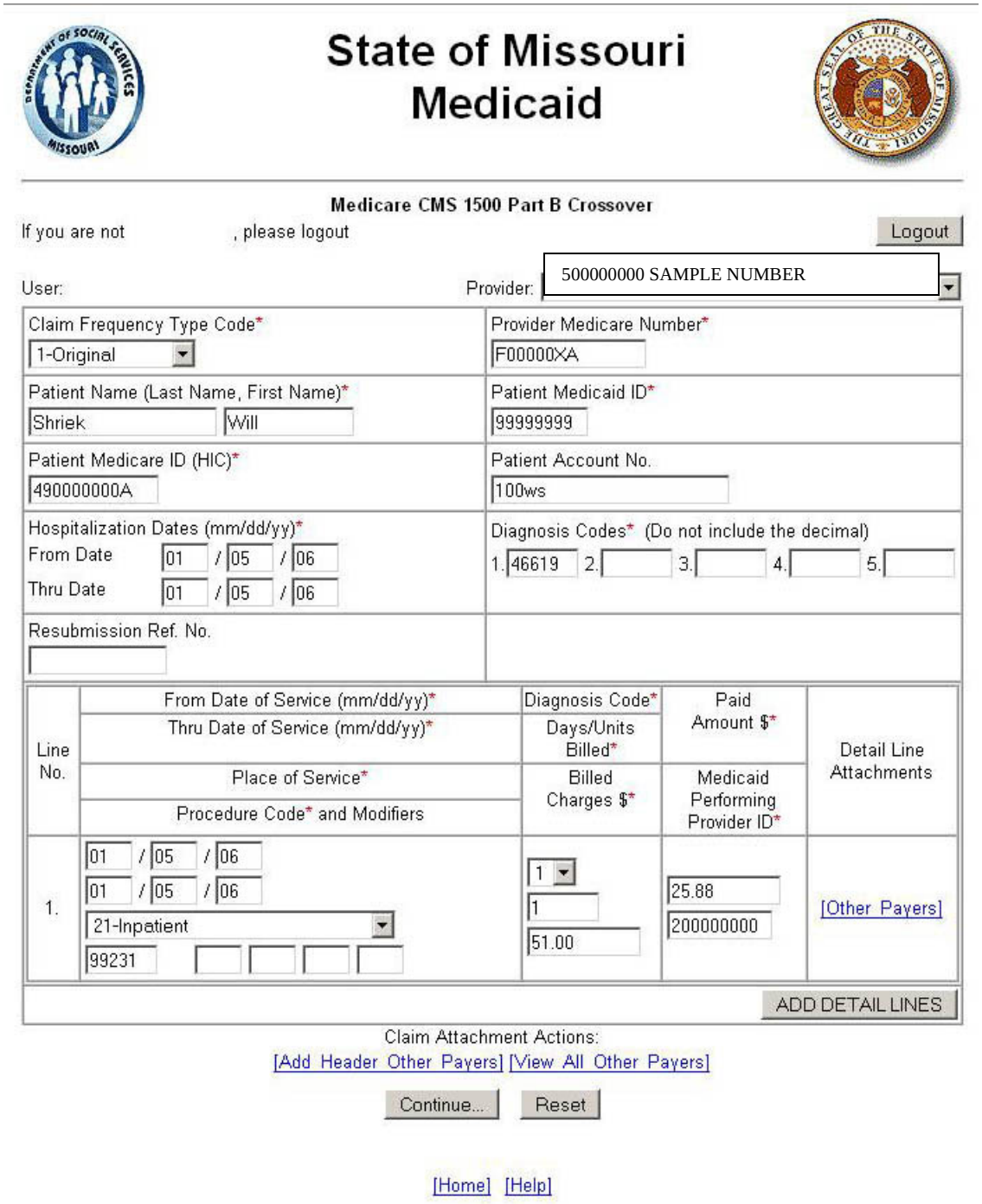
Remove Payer #2

Add Payer

Done Cancel

[Help]

- **Now you are on the "Other Payer Header" screen. Enter the information at the top as shown. For Part B and Part B of A crossover claims, do not complete the Group Codes, Reason Codes and Adjustment Amounts information. You will be entering this information elsewhere.**
- **Using the commercial insurance EOB, enter the appropriate information. The header allowed amount for this section is the amount you billed to Medicare, <u>not</u> the amount allowed by the commercial plan. If the commercial plan did not assign the claim a number, enter six (6) nines in the Medicare claim number field for payer #2.**
- **Click on "Done".**



State of Missouri
Medicaid

Medicare CMS 1500 Part B Crossover

If you are not , please logout Logout

User: Provider: 500000000 SAMPLE NUMBER

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: F00000XA
Patient Name (Last Name, First Name)*: Shriek, Will	Patient Medicaid ID*: 99999999
Patient Medicare ID (HIC)*: 490000000A	Patient Account No.: 100ws
Hospitalization Dates (mm/dd/yy)*: From Date 01/05/06; Thru Date 01/05/06	Diagnosis Codes* (Do not include the decimal): 1. 46619 2. 3. 4. 5.
Resubmission Ref. No.	

Line No.	From Date of Service (mm/dd/yy)* / Thru Date of Service (mm/dd/yy)* / Place of Service* / Procedure Code* and Modifiers	Diagnosis Code* / Days/Units Billed* / Billed Charges $*	Paid Amount $* / Medicaid Performing Provider ID*	Detail Line Attachments
1.	01/05/06; 01/05/06; 21-Inpatient; 99231	1; 1; 51.00	25.88; 200000000	[Other Payers]

ADD DETAIL LINES

Claim Attachment Actions:
[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **Now you are back on the original screen ready to add your detail information to the claim.**
- **Again, using the Medicare EOMB example from the previous page, enter the detail information as shown above.**
- **When done entering the information, click on "Other Payers" to add the Medicare and commercial insurance detail information.**

State of Missouri Medicaid

Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare CMS 1500 Part B Crossover claim.

Fields marked * must be filled in.

Claim Detail Line #1

Other Payer #1

Paid Date (mm/dd/yy)* 02 / 01 / 06

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO-Contractual Obligation	042	18.65	PR-Patient Responsibility	002	6.47

Add Reason Codes

Remove Payer #1

Other Payer #2

Paid Date (mm/dd/yy)* 02 / 16 / 06

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
OA-Other Adjustments	023	25.88	CO-Contractual Obligation	042	18.65
PR-Patient Responsibility	002	1.29			

Add Reason Codes

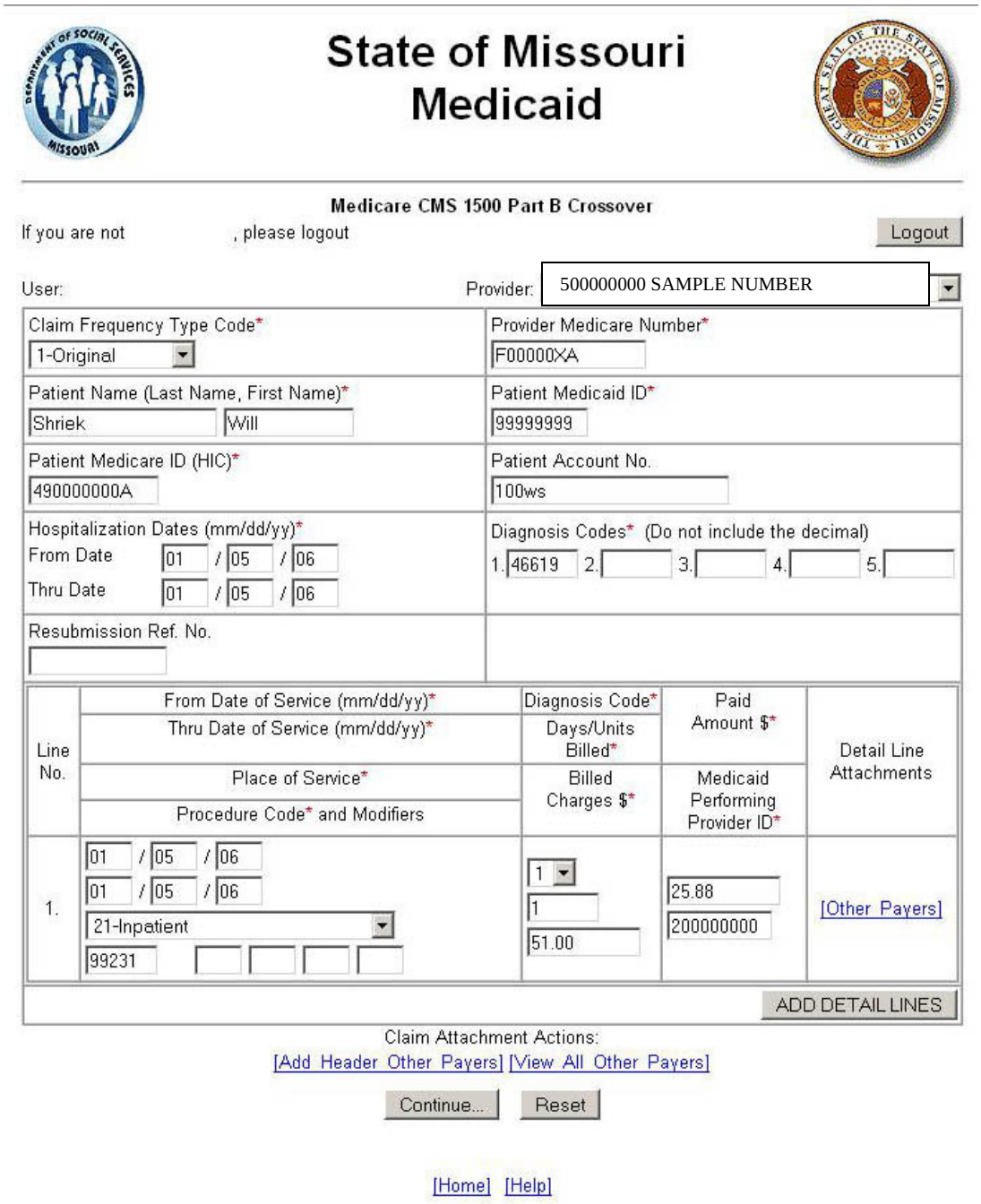
Remove Payer #2

Add Payer

Done Cancel

[Help]

- **Now you are on the "Other Payer Detail" screen. Complete the Medicare paid date information as well as the Group and Reason Codes and Adjustment Amounts. See above sample. If the reason codes are not listed on your Medicare EOMB, choose the most appropriate code from the list of "Claim Adjustment Reason Codes" from the HIPAA Related Code List. For example, the code on the "Claim Adjustment Reason Code" list for deductible amount is 1 and for coinsurance amount is 2. Therefore, you would enter a Reason Code of 001 for deductible amounts and 002 for coinsurance amounts due.**
- **The "Adjust Amount" should reflect any amount not paid by Medicare including deductible, coinsurance and any non-allowed amounts.**
- **Enter the same information for the commercial carrier. Your first entry should be "OA-Other Adjustment" 023. This is the amount Medicare has already reimbursed. If any adjustment codes are not listed on the commercial insurance EOB, choose the most appropriate code from the HIPAA related code list.**
- **Click on "Done".**



State of Missouri
Medicaid

Medicare CMS 1500 Part B Crossover

If you are not , please logout Logout

User: Provider: 500000000 SAMPLE NUMBER

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: F00000XA
Patient Name (Last Name, First Name)*: Shriek, Will	Patient Medicaid ID*: 99999999
Patient Medicare ID (HIC)*: 490000000A	Patient Account No.: 100ws
Hospitalization Dates (mm/dd/yy)*: From Date 01/05/06; Thru Date 01/05/06	Diagnosis Codes* (Do not include the decimal): 1. 46619 2. 3. 4. 5.
Resubmission Ref. No.	

Line No.	From Date of Service (mm/dd/yy)* / Thru Date of Service (mm/dd/yy)* / Place of Service* / Procedure Code* and Modifiers	Diagnosis Code* / Days/Units Billed* / Billed Charges $*	Paid Amount $* / Medicaid Performing Provider ID*	Detail Line Attachments
1.	01/05/06; 01/05/06; 21-Inpatient; 99231	1; 1; 51.00	25.88; 200000000	[Other Payers]

ADD DETAIL LINES

Claim Attachment Actions:
[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **This brings you back to the original screen. At this point, you are done entering the information. Click on "Continue".**
- **This brings you to a screen asking you to verify the information entered.**
- **You can either edit the information or submit.**
- **Click on "Submit". After submitting your claim, you will be brought to a screen which states, "Thank you. Your claim has been received". Click on the "Print" button at the bottom of the screen to print off and save for your records.**
- **To enter another claim, click on "Next".**

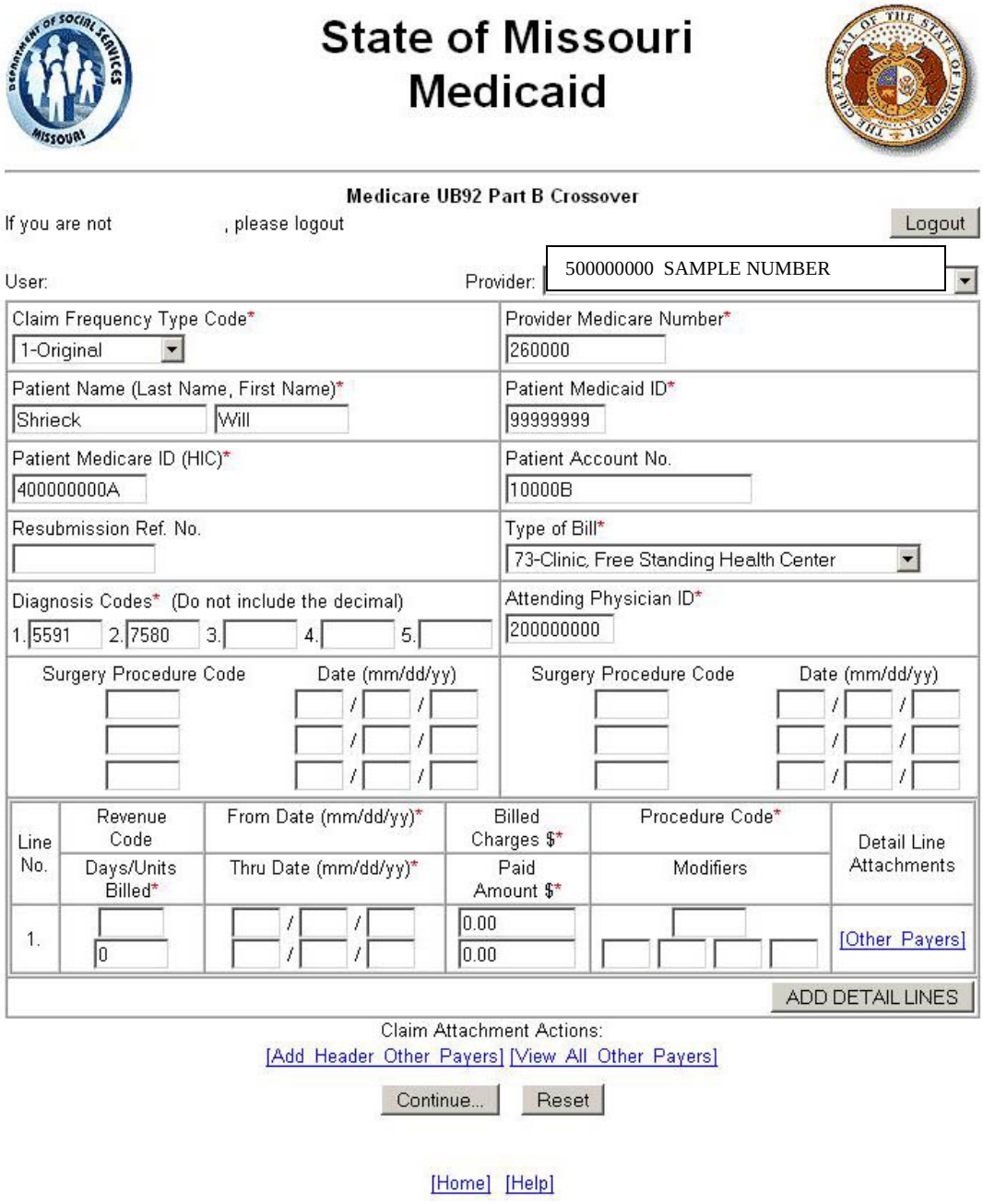
The end.

FQHC - PART B OF A (NO TPL)

UNITED GOVERNMENT SERVICES, LLC.			401 W. MICHIGAN ST. MILWAUKEE, WI 53203-2804					VER# 4010A1
260000	MID-MO HEALTH SERVICES		PART B	PAID DATE: 03/01/2006		REMIT #: 95000		PAGE: 1
PATIENT NAME	PATIENT CNTRL NUMBER	RC	REM	DRG #	DRG OUT AMT	COINSURANCE	PAT REFUND	CONTRACT ADJ
HIC NUMBER	ICN NUMBER	RC	REM	OUTCD CAPCD	NEW TECH/ECT	COVD CHGS	ESRD NET ADJ	PER DIEM RTE
FROM DT THRU DT	NACHG HICHG TOB	RC	REM	PROF COMP	MSP PAYMT	NCOVD CHGS	INTEREST	PROC CD AMT
CLM STATUS	COST COVDY NCOVDY	RC	REM	DRG AMT	DEDUCTIBLES	DENIED CHGS	PRE PAY ADJ	NET REIMB
SHRIECK, W W	10000B	94	MA01		.00	10.20	.00	31.28-
400000000A	20603500000000	2			.00	51.00	.00	90.10
02/01/2006 02/01/2006	731			.00	.00	.00	.00	.00
19				.00	.00	.00	.00	72.08

▶ **Using this example of a Medicare EOMB, the following pages will guide you step-bystep through the process to file your Crossover Claim through the Medicaid billing web site at www.emomed.com to collect the co-insurance/deductible amount.**

Please turn the page.



State of Missouri
Medicaid

Medicare UB92 Part B Crossover

If you are not , please logout Logout

User: Provider: 500000000 SAMPLE NUMBER

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: 260000
Patient Name (Last Name, First Name)*: Shrieck, Will	Patient Medicaid ID*: 99999999
Patient Medicare ID (HIC)*: 400000000A	Patient Account No.: 10000B
Resubmission Ref. No.:	Type of Bill*: 73-Clinic, Free Standing Health Center
Diagnosis Codes* (Do not include the decimal) 1. 5591 2. 7580 3. 4. 5.	Attending Physician ID*: 200000000
Surgery Procedure Code / Date (mm/dd/yy)	Surgery Procedure Code / Date (mm/dd/yy)

Line No.	Revenue Code / Days/Units Billed*	From Date (mm/dd/yy)* / Thru Date (mm/dd/yy)*	Billed Charges $* / Paid Amount $*	Procedure Code* / Modifiers	Detail Line Attachments
1.	0		0.00 / 0.00		[Other Payers]

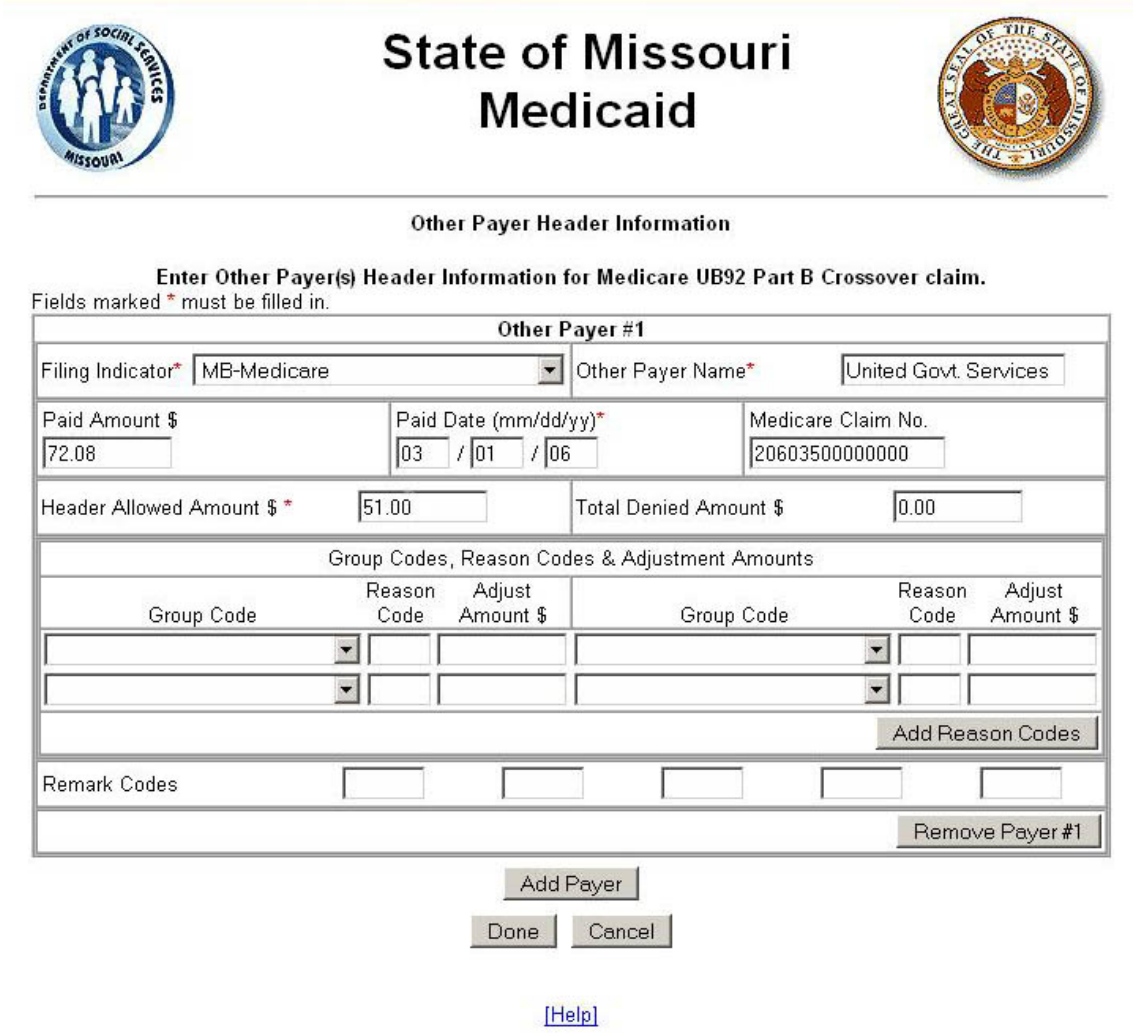
ADD DETAIL LINES

Claim Attachment Actions:
[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **At the Medicaid billing Web site, click on "Medicare UB92 Part B of A Crossover". This will bring you to the screen above.**
- **Enter all the Medicaid header information. Refer to the Medicare EOMB on the previous page as well as the patient's medical record. Complete the fields as shown above then click on the "Add Header Other Payers" link at the bottom of the page to enter the header other payer information.**



State of Missouri
Medicaid

Other Payer Header Information

Enter Other Payer(s) Header Information for Medicare UB92 Part B Crossover claim.
Fields marked * must be filled in.

Other Payer #1

Filing Indicator*	MB-Medicare	Other Payer Name*	United Govt. Services
Paid Amount $	72.08	Paid Date (mm/dd/yy)*	03 / 01 / 06
Medicare Claim No.	20603500000000		
Header Allowed Amount $ *	51.00	Total Denied Amount $	0.00

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $

Add Reason Codes

Remark Codes

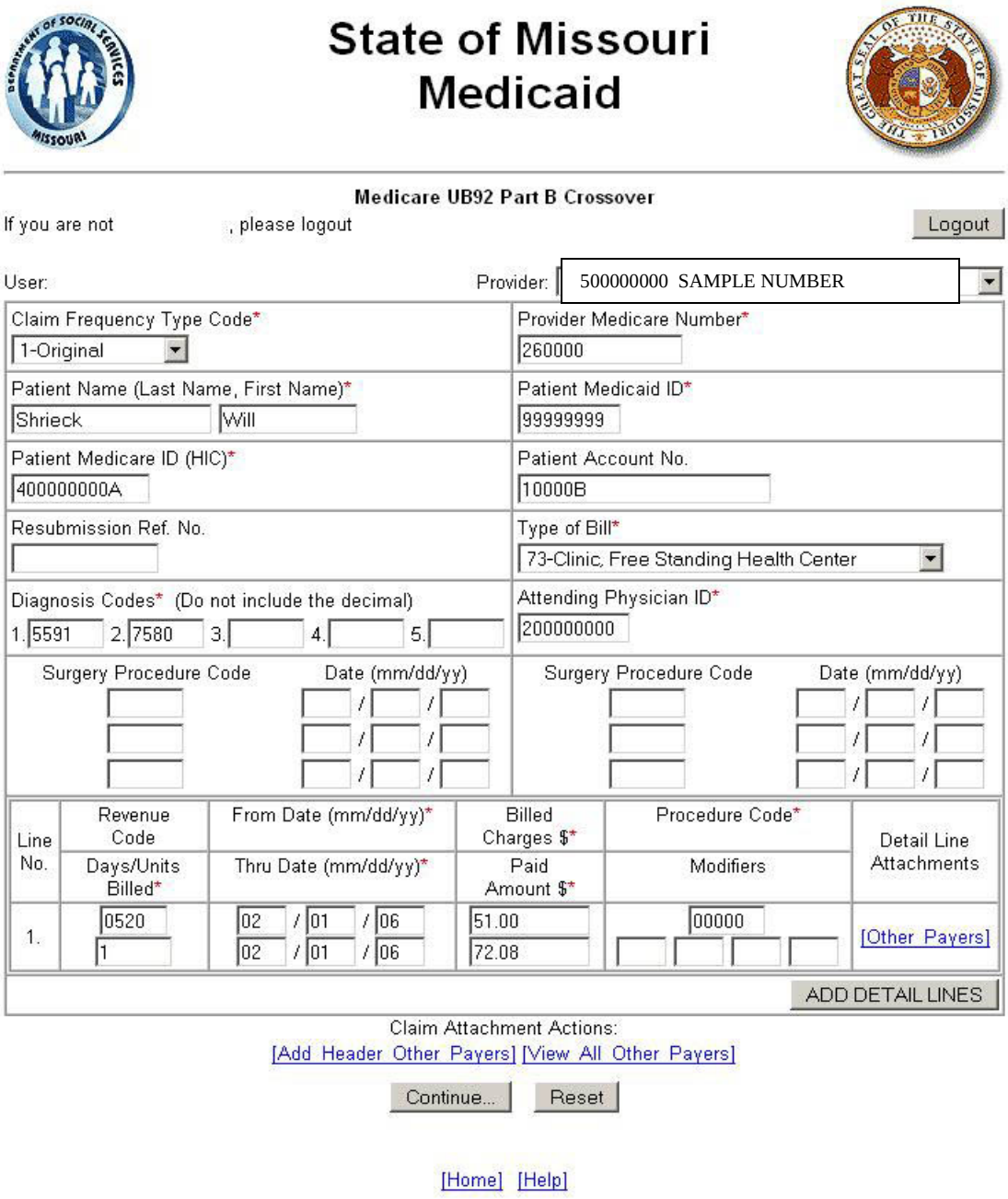
Remove Payer #1

Add Payer

Done Cancel

[Help]

- **Now you are on the "Other Payer Header" screen.**
- **Enter the information as shown. For Part B and Part B of A crossover claims, you do not enter the Group Codes, Reason Codes and Adjustment Amounts information. You will be entering this information elsewhere.**
- **Click on "Done".**



State of Missouri
Medicaid

Medicare UB92 Part B Crossover

If you are not , please logout Logout

User: Provider: 500000000 SAMPLE NUMBER

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: 260000
Patient Name (Last Name, First Name)*: Shrieck, Will	Patient Medicaid ID*: 99999999
Patient Medicare ID (HIC)*: 400000000A	Patient Account No.: 10000B
Resubmission Ref. No.:	Type of Bill*: 73-Clinic, Free Standing Health Center
Diagnosis Codes* (Do not include the decimal): 1. 5591 2. 7580 3. 4. 5.	Attending Physician ID*: 200000000

Surgery Procedure Code	Date (mm/dd/yy)	Surgery Procedure Code	Date (mm/dd/yy)
	/ /		/ /
	/ /		/ /
	/ /		/ /

Line No.	Revenue Code / Days/Units Billed*	From Date (mm/dd/yy)* / Thru Date (mm/dd/yy)*	Billed Charges $* / Paid Amount $*	Procedure Code* / Modifiers	Detail Line Attachments
1.	0520 / 1	02/01/06 / 02/01/06	51.00 / 72.08	00000	[Other Payers]

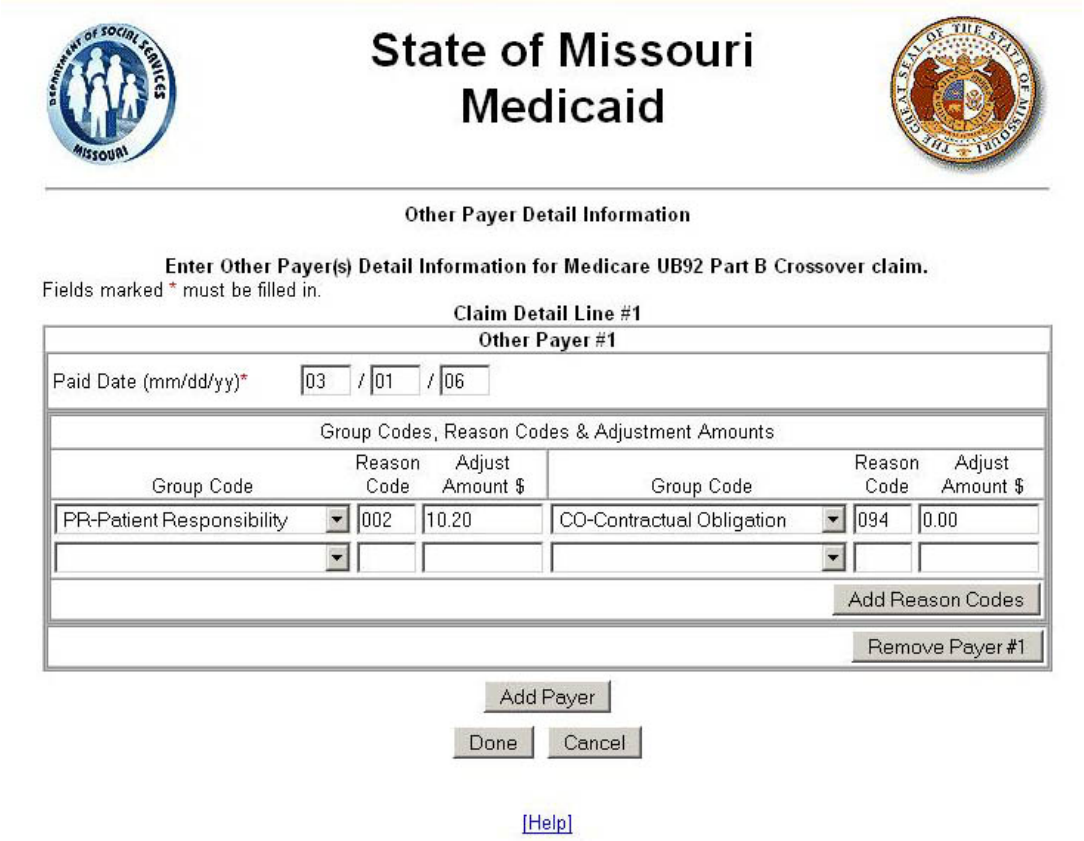
ADD DETAIL LINES

Claim Attachment Actions:
[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **Now you are back on the original screen ready to add your detail information to the claim.**
- **Again, using the Medicare EOMB example from the first page, enter the detail information as shown above. If you did not report a procedure code to Medicare, enter "00000" in the Procedure Code Field.**
- **When done entering the information, click on "Other Payers" to add the Medicare detail information.**



State of Missouri
Medicaid

Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare UB92 Part B Crossover claim.
Fields marked * must be filled in.

Claim Detail Line #1

Other Payer #1

Paid Date (mm/dd/yy)* 03 / 01 / 06

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
PR-Patient Responsibility	002	10.20	CO-Contractual Obligation	094	0.00

Add Reason Codes

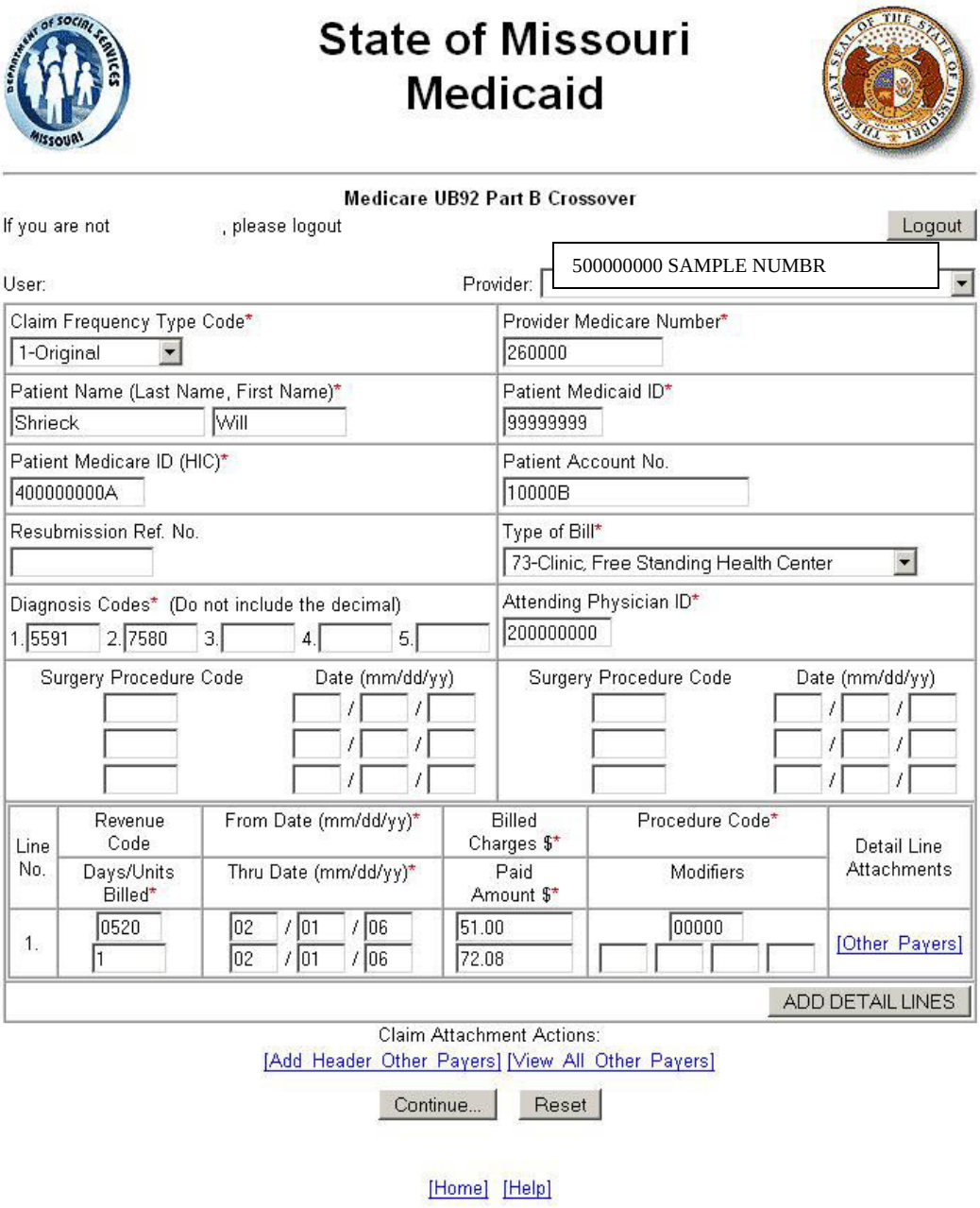
Remove Payer #1

Add Payer

Done Cancel

[Help]

- **Now you are on the "Other Payer Detail" screen.**
- **Enter the Medicare paid date information as well as the Group and Reason Codes and Adjustment Amounts. See the above sample. If the reason codes are not listed on your Medicare EOMB, choose the most appropriate code from the list of "Claim Adjustment Reason Codes" from the HIPAA Related Code List. For example, the code on the Claim Adjustment Reason Code list for deductible amount is 1 and for coinsurance amount is 2. Therefore, you would enter a Reason Code of 001 for deductible amounts and 002 for coinsurance amounts due.**
- **The "Adjust Amount" should reflect any amount not paid by Medicare including deductible, coinsurance and any non-allowed amounts.**
- **Medicare may report a negative "Contractual Adjustment" amount on the Medicare EOMB. When this occurs, enter the appropriate group and reason codes with a "zero" adjustment amount.**
- **Click on "Done".**



State of Missouri
Medicaid

Medicare UB92 Part B Crossover

If you are not , please logout Logout

User: Provider: 500000000 SAMPLE NUMBR

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: 260000
Patient Name (Last Name, First Name)*: Shrieck, Will	Patient Medicaid ID*: 99999999
Patient Medicare ID (HIC)*: 400000000A	Patient Account No.: 10000B
Resubmission Ref. No.:	Type of Bill*: 73-Clinic, Free Standing Health Center
Diagnosis Codes* (Do not include the decimal): 1. 5591 2. 7580 3. 4. 5.	Attending Physician ID*: 200000000

Surgery Procedure Code	Date (mm/dd/yy)	Surgery Procedure Code	Date (mm/dd/yy)
	/ /		/ /
	/ /		/ /
	/ /		/ /

Line No.	Revenue Code / Days/Units Billed*	From Date (mm/dd/yy)* / Thru Date (mm/dd/yy)*	Billed Charges $* / Paid Amount $*	Procedure Code* / Modifiers	Detail Line Attachments
1.	0520 / 1	02/01/06 / 02/01/06	51.00 / 72.08	00000	[Other Payers]

ADD DETAIL LINES

Claim Attachment Actions:
[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **This brings you back to the original screen. At this point, you are done entering the information. Click on "Continue".**
- **This brings you to a screen asking you to verify the information entered. You can either edit the information or submit.**
- **Click on "Submit".**
- **After submitting your claim, you will be brought to a screen which states, "Thank you. Your claim has been received". Click on the "Print" button at the bottom of the screen to print off and save for your records.**
- **To enter another claim, click on "Next".**

THE END

SAMPLE - MEDICARE REMITTANCE

PART B OF A - DIALYSIS CLINIC

Medicare National Standard Intermediary Remittance Advice

FPE: 12/31/2005

PAID: 03/01/2006

CLM# : 263

26XXXX TOB: 721

TRANSFER TO (COB): MISSOURI MEDICAID ID CODE: T468XXXXX

PATIENT: SHRIEK WILL PCN: 13800000

HIC: 400000000T SVC FROM: 01/02/2006 MRN:

PAT STAT: CLAIM STAT: 19 THRU: 01/29/2006 ICN: 20603800000000

CHARGES:
27937.50=REPORTED
0.00=NCVD/DENIED
0.00=CLAIM ADJS.
4415.79=COVERED

DAYS/VISITS:
0=COST REPT
0=COVD/UTIL
0=NON-COVERED
0=COVD VISITS
0=NCOV VISITS

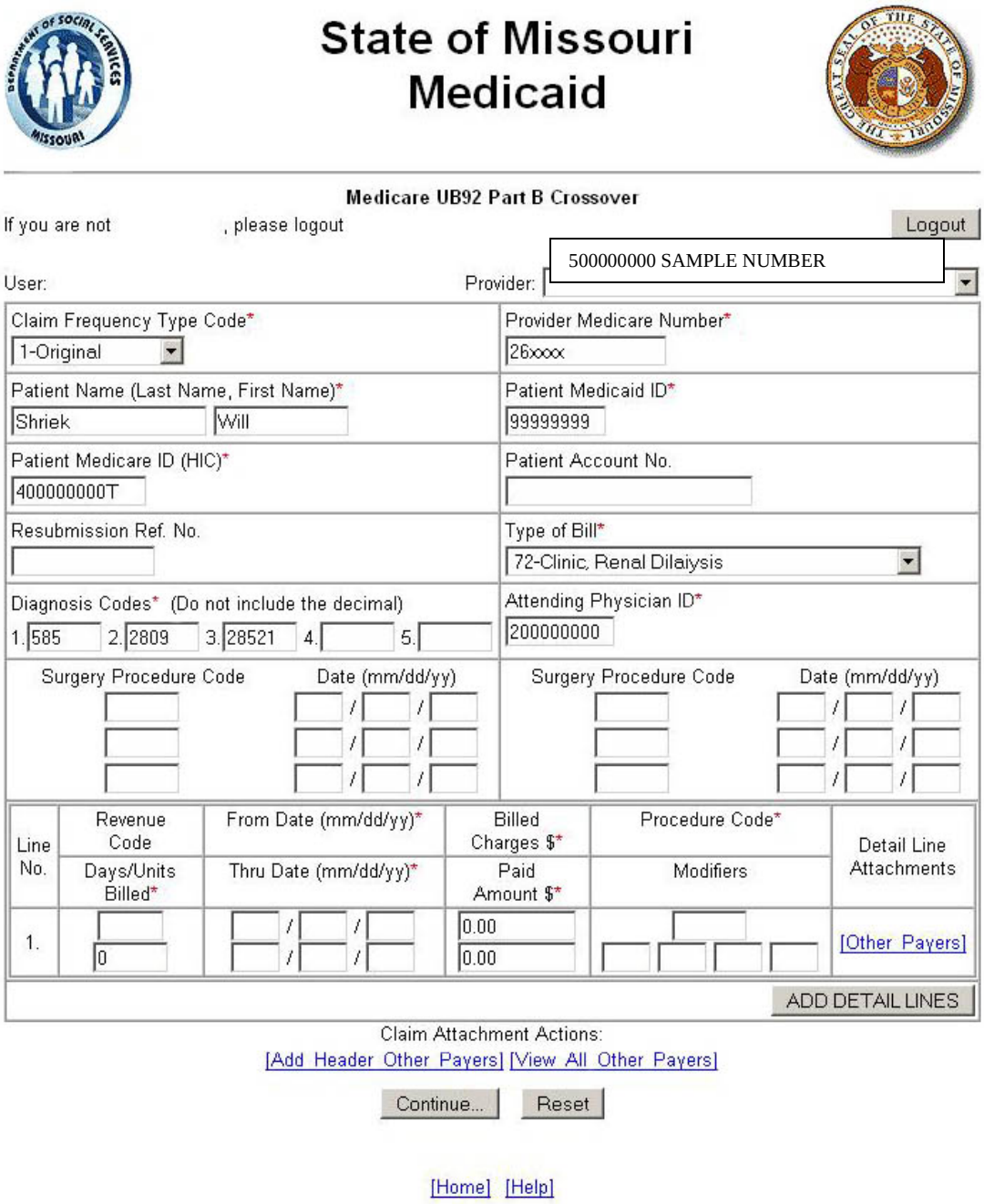
PAYMENT DATA: =DRG
0.00=DRG AMOUNT
0.00=DRG/OPER/CAP
24142.83=LINE ADJ-AMT
0.00=OUTLIER
0.00=CAP OUTLIER
0.00=CASH DEDUCT
0.00=BLOOD DEDUCT
758.93=COINSURANCE
0.00=PAT REFUND
0.00=MSP LIAB MET

1.000=REIM RATE
0.00=MSP PRIM PAYER
0.00=PROF COMPONENT
6.50=ESRD AMOUNT
6.00=PROC CD AMOUNT
3029.24=ALLOW/REIM
0.00=G/R AMOUNT
0.00=INTEREST
0.00=CONTRACT ADJ
1.00=PER DIEM AMT
3029.24=NET REIM AMT

REMARK CODES: MA01

REV	DATE	HCPCS	APC/HIPPS MODS	QTY	CHARGES	ALLOW/REIM	GC	RSN	AMOUNT	REMARK CODES
0270	01/02	A4657		12	627.12	4.80	CO	42	621.12	
							PR	2	1.20	
0635	01/02	Q4055		12	13461.48	974.44	CO	45	12243.43	
							PR	2	243.61	
0821	01/02	90999		13	13848.90	2050.00	CO	118	6.50	
								45	11278.28	
							PR	2	514.12	

- **Using this example of a Medicare EOMB, the following pages will guide you step-by-step through the process to file your crossover claim through the Medicaid billing Web site at www.emomed.com to collect the deductible/coinsurance amount.**



State of Missouri
Medicaid

Medicare UB92 Part B Crossover

If you are not , please logout Logout

500000000 SAMPLE NUMBER

User: Provider:

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: 26xxxx
Patient Name (Last Name, First Name)*: Shriek, Will	Patient Medicaid ID*: 99999999
Patient Medicare ID (HIC)*: 400000000T	Patient Account No.:
Resubmission Ref. No.:	Type of Bill*: 72-Clinic, Renal Dilaiysis
Diagnosis Codes* (Do not include the decimal): 1. 585 2. 2809 3. 28521 4. 5.	Attending Physician ID*: 200000000

Surgery Procedure Code	Date (mm/dd/yy)	Surgery Procedure Code	Date (mm/dd/yy)
	/ /		/ /
	/ /		/ /
	/ /		/ /

Line No.	Revenue Code / Days/Units Billed*	From Date (mm/dd/yy)* / Thru Date (mm/dd/yy)*	Billed Charges $* / Paid Amount $*	Procedure Code* / Modifiers	Detail Line Attachments
1.	0	/ /	0.00 / 0.00		[Other Payers]

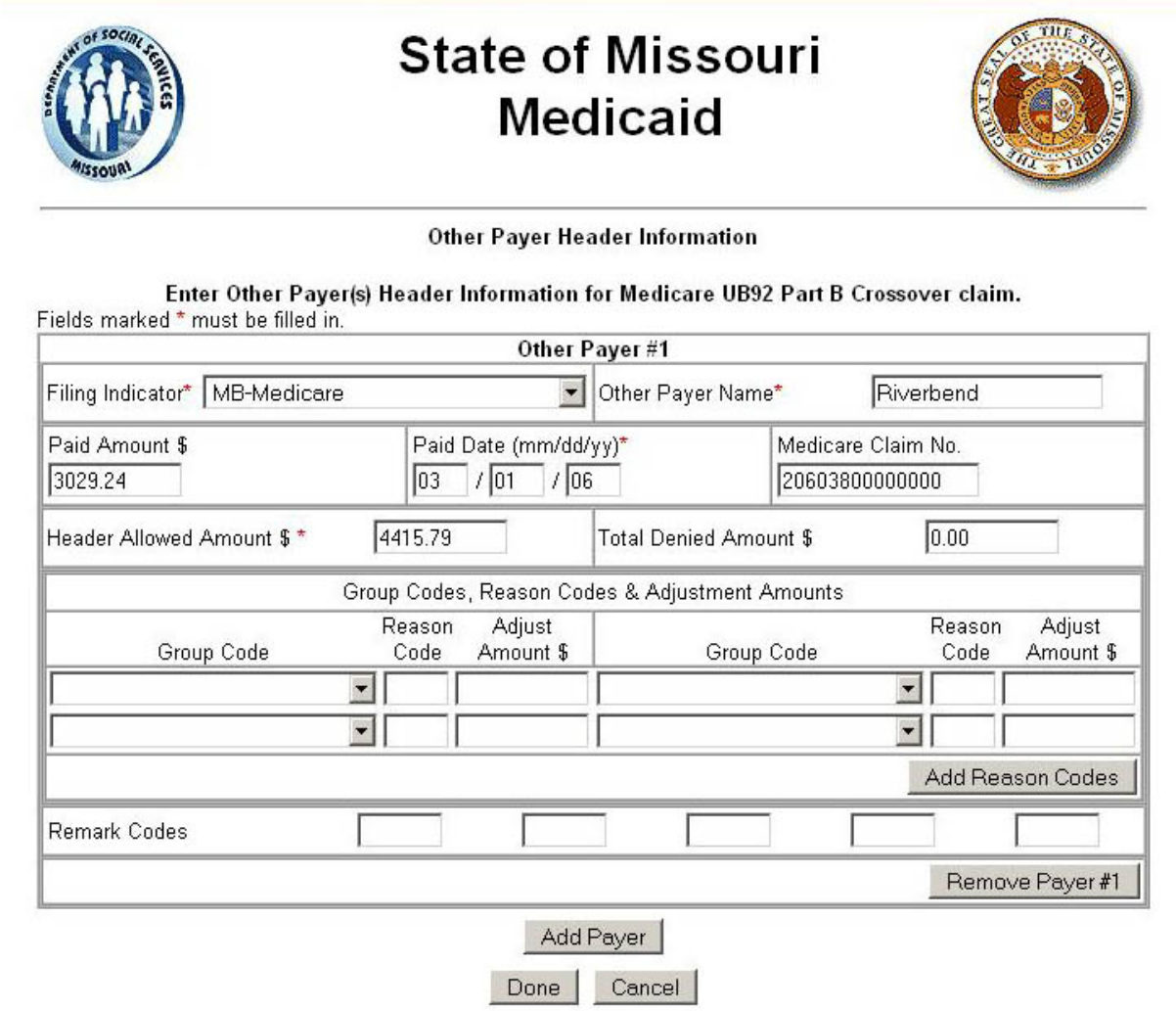
ADD DETAIL LINES

Claim Attachment Actions:
[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **At the Medicaid billing Web site, click on “Medicare UB92 Part B of A Crossover”. This brings you to the screen above.**
- **Enter all the Medicaid header information. Refer to the Medicare EOMB on the previous page as well as the patient’s medical record. Complete the fields as shown above. Then click on the “Add Header Other Payers” link at the bottom of the page to enter the header other payer information.**



State of Missouri
Medicaid

Other Payer Header Information

Enter Other Payer(s) Header Information for Medicare UB92 Part B Crossover claim.

Fields marked * must be filled in.

Other Payer #1

Filing Indicator*	MB-Medicare	Other Payer Name*	Riverbend
Paid Amount $	3029.24	Paid Date (mm/dd/yy)*	03 / 01 / 06
Medicare Claim No.	20603800000000		
Header Allowed Amount $ *	4415.79	Total Denied Amount $	0.00

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $

Add Reason Codes

Remark Codes					

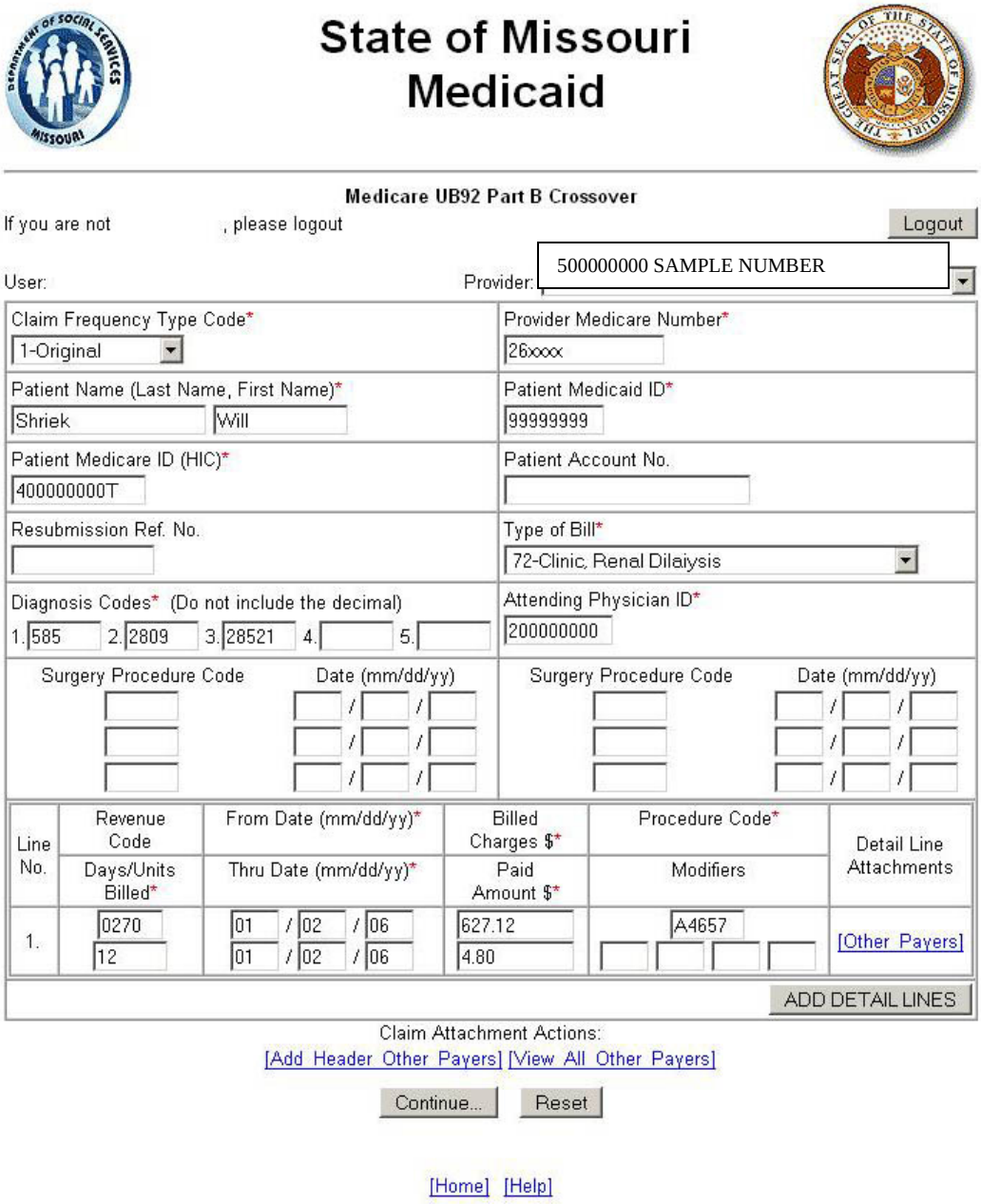
Remove Payer #1

Add Payer

Done Cancel

[Help]

- **Now you are on the "Other Payer Header" screen.**
- **Enter the information as shown. For Part B and Part B of A crossover claims, do not complete the Group Codes, Reason Codes and Adjustment Amounts information. You will enter this information elsewhere.**
- **Click on "Done".**



State of Missouri
Medicaid

Medicare UB92 Part B Crossover

If you are not , please logout Logout

User: Provider: 500000000 SAMPLE NUMBER

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: 26xxxx
Patient Name (Last Name, First Name)*: Shriek, Will	Patient Medicaid ID*: 99999999
Patient Medicare ID (HIC)*: 400000000T	Patient Account No.:
Resubmission Ref. No.:	Type of Bill*: 72-Clinic, Renal Dilaiysis
Diagnosis Codes* (Do not include the decimal): 1. 585 2. 2809 3. 28521 4. 5.	Attending Physician ID*: 200000000

Surgery Procedure Code	Date (mm/dd/yy)	Surgery Procedure Code	Date (mm/dd/yy)
	/ /		/ /
	/ /		/ /
	/ /		/ /

Line No.	Revenue Code / Days/Units Billed*	From Date (mm/dd/yy)* / Thru Date (mm/dd/yy)*	Billed Charges $* / Paid Amount $*	Procedure Code* / Modifiers	Detail Line Attachments
1.	0270 / 12	01/02/06 / 01/02/06	627.12 / 4.80	A4657	[Other Payers]

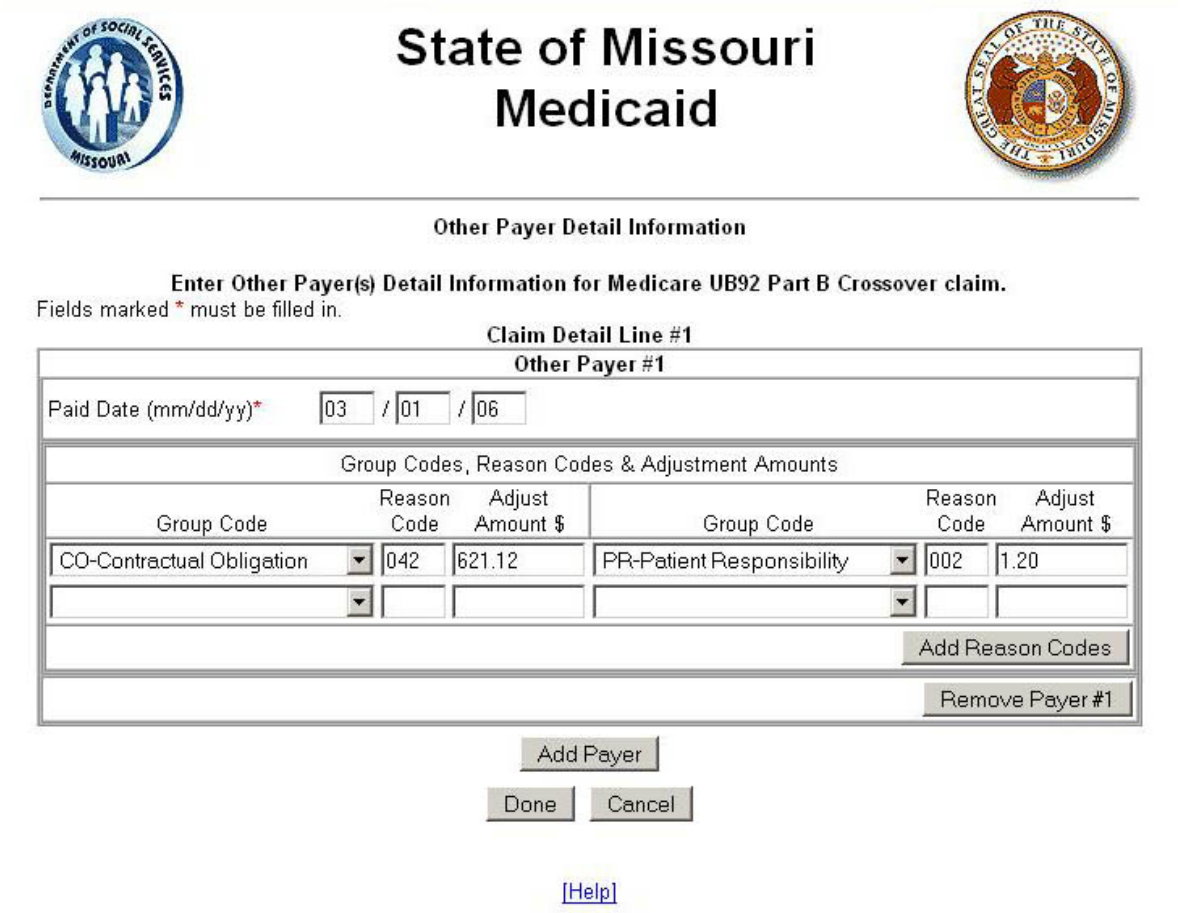
ADD DETAIL LINES

Claim Attachment Actions:
[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **You are now back to the original screen ready to add your detail information to the claim.**
- **Again using the Medicare EOMB example from the first page, enter the detail information shown above for line one. If you did not report a procedure code to Medicare, enter "00000" in the Procedure Code field.**
- **When done entering the information, click on "Other Payers" to add the Medicare detail information.**



State of Missouri
Medicaid

Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare UB92 Part B Crossover claim.
Fields marked * must be filled in.

Claim Detail Line #1

Other Payer #1

Paid Date (mm/dd/yy)* 03 / 01 / 06

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO-Contractual Obligation	042	621.12	PR-Patient Responsibility	002	1.20

Add Reason Codes

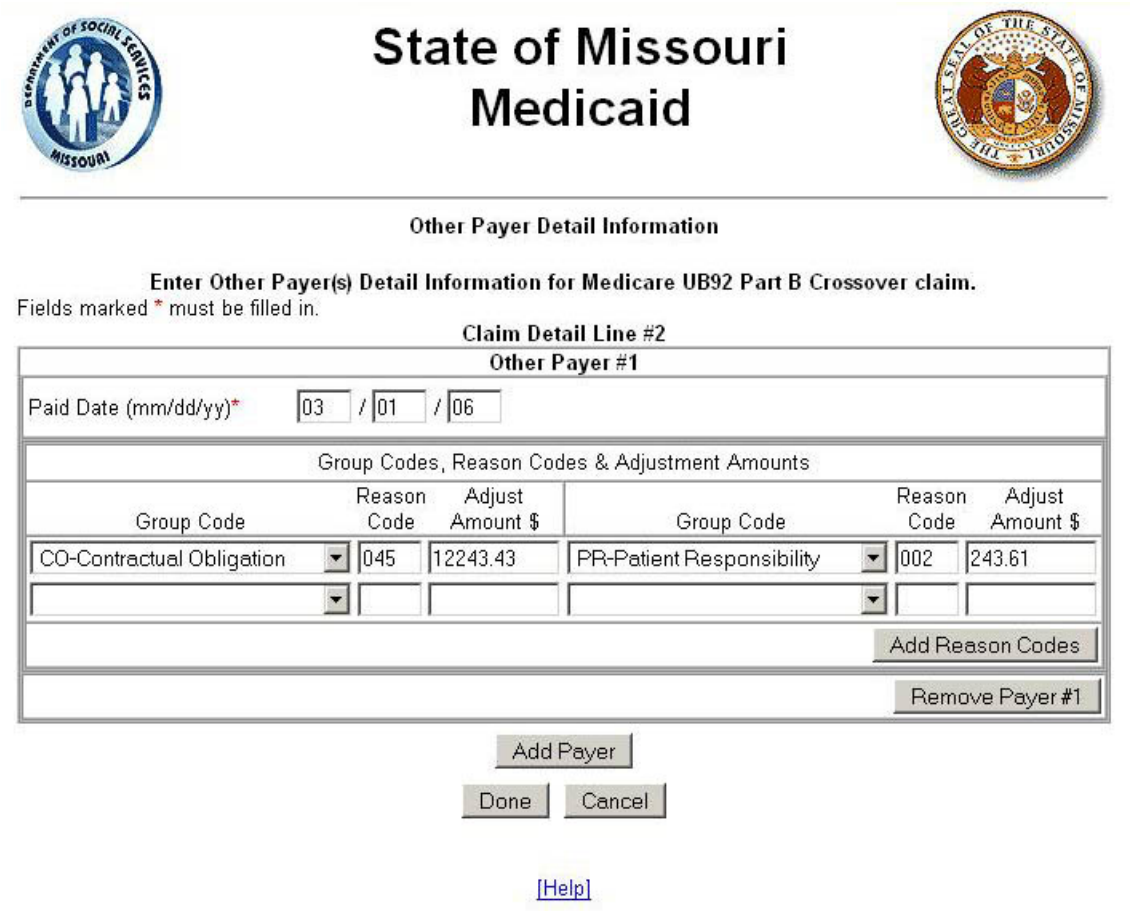
Remove Payer #1

Add Payer

Done Cancel

[Help]

- **Now you are on the "Other Payer Detail" Screen. Scroll to the bottom of the form and click on the "Help" button, print off and save the instructions.**
- **Scroll back to the top, complete the Medicare paid date information as well as the Group and Reason Codes and Adjustment Amounts. See above sample. If the reason codes are not listed on your Medicare EOMB, choose the most appropriate code from the list of "Claim Adjustment Reason Codes" from the HIPAA Related Code List. For example, the code on the "Claim Adjustment Reason Code" list for deductible amount is 1 and for coinsurance amount is 2. Therefore, you would enter a Reason Code of 001 for deductible amounts and 002 for coinsurance amounts due.**
- **The "Adjust Amount" should reflect any amount not paid by Medicare including deductible, coinsurance and any non-allowed amounts.**
- **Click on "Done".**



State of Missouri
Medicaid

Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare UB92 Part B Crossover claim.
Fields marked * must be filled in.

Claim Detail Line #2

Other Payer #1

Paid Date (mm/dd/yy)* 03 / 01 / 06

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO-Contractual Obligation	045	12243.43	PR-Patient Responsibility	002	243.61

Add Reason Codes

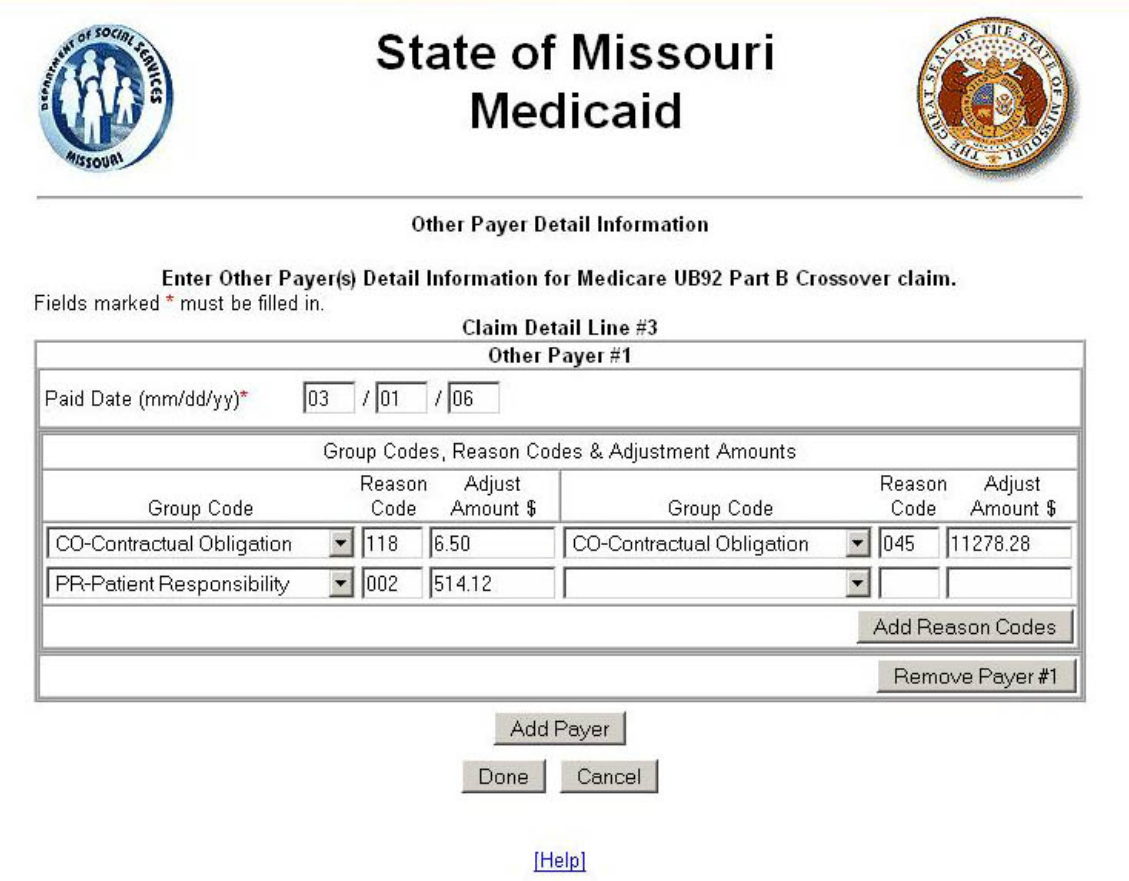
Remove Payer #1

Add Payer

Done Cancel

[Help]

- **Enter a claim detail line and "Other Payer Detail" for each line from your Medicare EOMB.**
- **This is a sample detail entry for line 2 showing both contractual and patient responsibility codes and amounts.**
- **After all claim detail lines have been entered, click "Done".**



State of Missouri
Medicaid

Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare UB92 Part B Crossover claim.
Fields marked * must be filled in.

Claim Detail Line #3

Other Payer #1

Paid Date (mm/dd/yy)* 03 / 01 / 06

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO-Contractual Obligation	118	6.50	CO-Contractual Obligation	045	11278.28
PR-Patient Responsibility	002	514.12			

Add Reason Codes

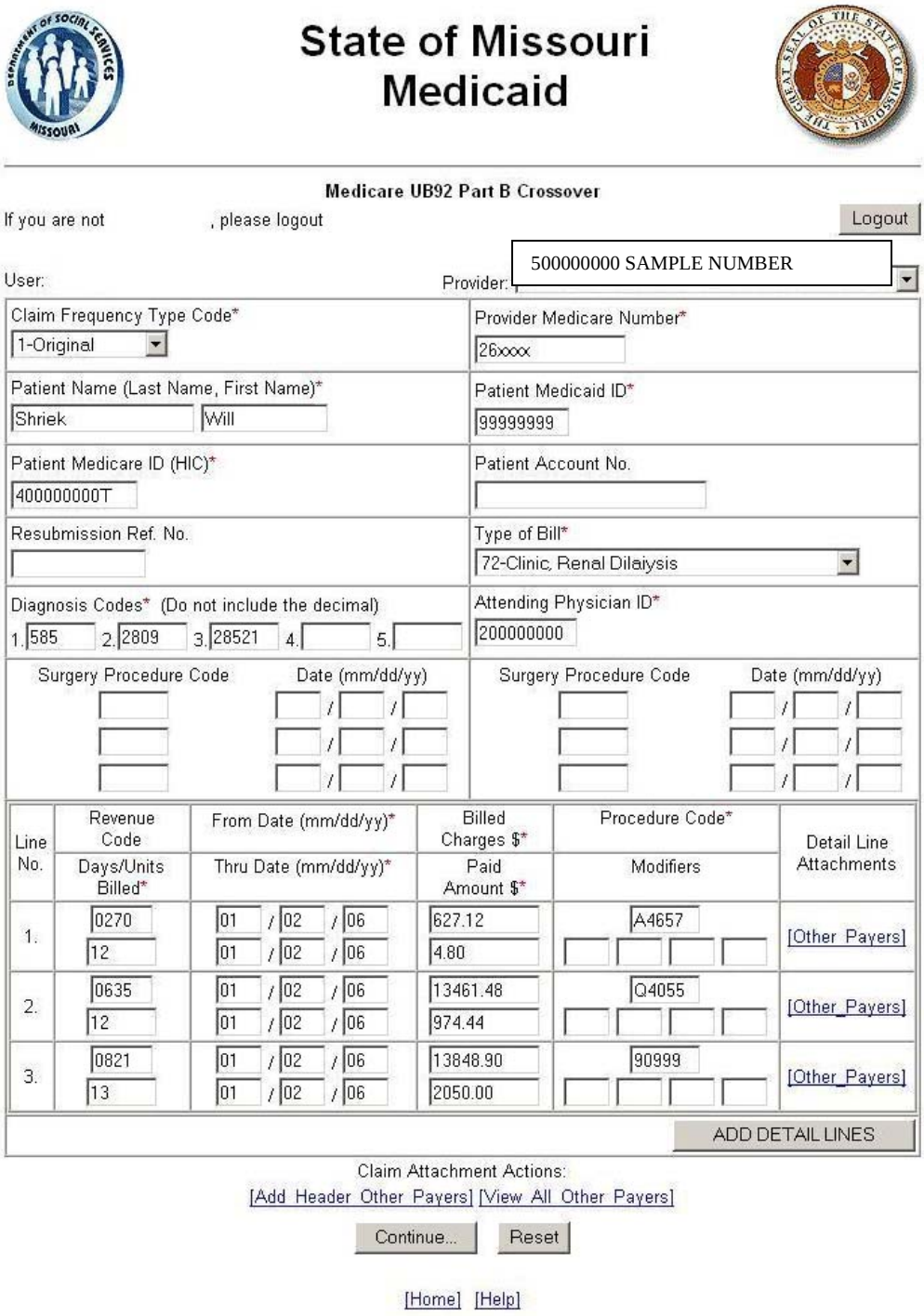
Remove Payer #1

Add Payer

Done Cancel

[Help]

- **Enter a claim detail line and "Other Payer Detail" for each line from your Medicare EOMB.**
- **This is a sample detail entry for line 3 showing both contractual and patient responsibility codes and amounts.**
- **After all claim detail lines have been entered, click "Done".**



State of Missouri
Medicaid

Medicare UB92 Part B Crossover

If you are not , please logout Logout

User: Provider: 500000000 SAMPLE NUMBER

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: 26xxxx
Patient Name (Last Name, First Name)*: Shriek, Will	Patient Medicaid ID*: 99999999
Patient Medicare ID (HIC)*: 400000000T	Patient Account No.:
Resubmission Ref. No.:	Type of Bill*: 72-Clinic, Renal Dilaiysis
Diagnosis Codes* (Do not include the decimal): 1. 585 2. 2809 3. 28521 4. 5.	Attending Physician ID*: 200000000

Surgery Procedure Code	Date (mm/dd/yy)	Surgery Procedure Code	Date (mm/dd/yy)
	/ /		/ /
	/ /		/ /
	/ /		/ /

Line No.	Revenue Code / Days/Units Billed*	From Date (mm/dd/yy)* / Thru Date (mm/dd/yy)*	Billed Charges $* / Paid Amount $*	Procedure Code* / Modifiers	Detail Line Attachments
1.	0270 / 12	01/02/06 / 01/02/06	627.12 / 4.80	A4657 /	[Other Payers]
2.	0635 / 12	01/02/06 / 01/02/06	13461.48 / 974.44	Q4055 /	[Other Payers]
3.	0821 / 13	01/02/06 / 01/02/06	13848.90 / 2050.00	90999 /	[Other Payers]

ADD DETAIL LINES

Claim Attachment Actions:
[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **When you click "Done" on the last line detail entry screen, you will be brought back to the original screen which should show the basic information for each detail line.**
- **Since you are now done entering the header and detail information, click on "Continue".**
- **This brings you to a screen asking you to verify the information entered.**

(continued on the next page)

- **You can either edit the information or submit. Click on 'Submit'.**
- **After submitting your claim, you will be brought to a screen which states, "Thank you. Your claim has been received". Click on the "Print" button at the bottom of the screen to print off this page and save for your records.**
- **To enter another claim, click on "Next".**

THE END

SECTION 5
THE REMITTANCE ADVICE

Missouri Medicaid discontinued printing and mailing paper Remittance Advices (RAs) to most providers effective July 20, 2004. The remittance advices now are available via the Internet through emomed.com. There are two versions available, the 837 format and the Printable RA.

With the implementation of Internet Remittance Advice, providers can:

- Retrieve a remittance advice the Monday following the weekend Financial Cycle run (two weeks sooner than the paper version);
- View and print the RA from your desktop; and
- Download the RA into your computer system for future reference.

More information on accessing and using the printable RA is found later in this section.

When a claim is adjudicated, it is included as a line item on the next RA. Along with listing the claim, the RA lists an "Adjustment Reason Code" to explain a payment, denial or other action. The Adjustment Reason Code is from a national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's reimbursement for it. The RA may also list a "Remittance Remark Code" which is from the same national administrative code set that indicates either a claim-level or service-level message that cannot be expressed with a claim Adjustment Reason Code. The Adjustment Reason Codes and Remittance Remark Codes may be found on the Division of Medical Services' website, www.dss.mo.gov/dms, and clicking on the link "HIPAA related code lists".

The date on the RA is the date the final processing cycle runs. Reimbursement will be made through a mailed check or a direct bank deposit approximately two weeks after the cycle run date. (See Claims Processing Schedule at the end of Section 1.)

The RA is grouped first by paid claims and then by denied claims. Claims in each category are listed alphabetically by the patient's last name. If the patient's name and/or Departmental Client Number (DCN) are **not** on file, only the first two letters of the last name and first letter of the first name appear.

Each claim entered into the claims processing system is assigned a 13-digit Internal Control Number (ICN) assigned for identification purposes. The first two digits of an ICN indicate the type of claim.

15 – Paper claim
18 – Paper Medicare Part B Crossover
40 – Electronic Medicare Crossover
49 – Internet claim

70 – Individual Credit to an Adjustment
50 – Individual Adjustment Request
75 – Credit Mass Adjustment
55 – Mass Adjustment

The third and fourth digits indicate the year the claim was received. The fifth, sixth, and seventh digits indicate the Julian date the claim was entered into the system. In the Julian system, the days are numbered consecutively from "001" (January 01) to "365" or "366" in a leap year (December 31). The last digits of an ICN are for internal processing.

The ICN 1504277315020 is read as a paper medical claim entered in the processing system on October 04, 2004.

If a claim is denied, a new or corrected claim form **must** be submitted as corrections **cannot** be made by submitting changes on the printed RA pages.

When a claim denies for other insurance, the commercial carrier information is shown. Up to two policies can be shown.

PRINTABLE REMITTANCE ADVICE

The Printable Internet Remittance Advice is accessed at www.emomed.com. A provider must be enrolled with emomed.com in order to access the website and the printable RA. To sign-up for emomed.com and the on-line Remittance Advice option, visit the Missouri Medicaid website, www.dss.mo.gov/dms, and select the Provider Information "internet access" link.

On the Printable Remittance Advice page, click on the RA date you wish to view, print or save and follow your Internet browser's instructions. The RA is in the PDF file format. Your browser will open the file directly if you have Adobe Acrobat Reader installed on your computer. If you do not have this program, go to http://www.adobe.com/products/acrobat/readsetp2.html to download it to your computer.

RAs are available automatically following each financial cycle. Each RA remains available for a total of 62 days. The oldest RA drops off as the newest becomes available. Therefore, providers are encouraged to save each RA to their computer system for future reference and use.

Note: When printing an RA, it is set to page break after 70 lines per page.

If a provider did not save an RA to his/her computer and wants access to an RA that is no longer available, the provider can request the RA through the "Aged RA Request" link on the emomed.com home page.

In general, the Printable Remittance Advice is displayed as follows.

Field	Description
RECIPIENT NAME	The recipient's last name and first name. NOTE: If the recipient's name and identification number are not on file, only the first two letters of the last name and first letter of the first name appear.
MEDICAID ID	The recipient's 8-digit Medicaid identification number.
ICN	The 13-digit number assigned to the claim for identification purposes.
SERVICE DATES FROM	The initial date of service in MMDDYY format for the claim.
SERVICE DATES TO	The final date of service in MMDDYY format for the claim.
PAT ACCT	The provider's own patient account name or number.
CLAIM: ST	This field reflects the status of the claim. Values are: 1 = Processed as Primary, 3 = Processed as Tertiary, 4 = Denied, 22 = Reversal of Previous Payment
TOT BILLED	The total claim amount submitted.
TOT PAID	The total amount Medicaid paid on the claim.
TOT OTHER	The combined totals for patient liability (surplus), recipient copay, and spenddown total withheld.
LN	The line number of the billed service.
SERVICE DATES	The date of service(s) for the specific detail line.
REV/PROC/NDC	The submitted procedure code, NDC, or revenue code for the specific detail line. Note: The revenue code will only appear in this field if a procedure code is not present.
MOD	The submitted modifier(s) for the specific detail line.
REV CODE	The submitted revenue code for the specific detail line. Note: The revenue code only appears in this field if a procedure code has also been submitted.
QTY	The units of service submitted.
BILLED AMOUNT	The submitted billed amount for the specific detail line.
ALLOWED AMOUNT	The Medicaid maximum allowed amount for the procedure.
PAID AMOUNT	The amount Medicaid paid on the claim.
PERF PROV	The Medicaid ID number for the performing provider submitted at the detail.

Field	Description
SUBMITTER LN ITM CNTL	The submitted line item control number.
GROUP CODE	The Claim Adjustment Group Code is a code identifying the general category of payment adjustment. Values are: CO = Contractual Obligation CR = Correction and Reversals OA = Other Adjustment PI = Payer Initiated Reductions PR = Patient Responsibility
RSN	The Claim Adjustment Reason Code is the code identifying the detailed reason the adjustment was made.
AMT	The dollar amount adjusted for the corresponding reason code.
QTY	The adjustment to the submitted units of service. This field will not be printed if the value is zero.
REMARK CODES	The Code List Qualifier Code and the Health Care Remark Code (Remittance Advice Remark Codes). The Code List Qualifier Code is a code identifying a specific industry code list. Values are: HE = Claim Payment Remark Code RX = National Council for Prescription Drug Programs Reject/Payment Codes. The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.
CATEGORY TOTALS	Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.

SECTION 6
MODIFIERS

Missouri Medicaid uses the following modifiers for the professional services.

Modifier	Description
26	Professional Component (required for laboratory, radiology, nuclear medicine/EEG/EKG services)
50	Bilateral Procedure
52	Reduced Services (for use only with EPSDT/HCY screening procedure codes and case management for pregnant women procedure code H1001TS52)
54	Surgical Care Only
55	Postoperative Management only
59	Distinct Procedure Service (used **only** to identify the components of an EPSDT/HCY screen when **only** those components related to developmental and mental health are being screened)
62	Two surgeons
63	Procedure performed on infants (used **only** with CPT codes 99231-99233 for dates of service 10/16/03 to 12/31/04)
80	Assistant Surgeon
AA	Anesthesia services performed personally by anesthesiologist
EP	Service provided as part of Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT/HCY) program
QK	Medical direction of two, three or four concurrent procedures involving qualified individuals
QX	CRNA service, with medical direction by physician
QZ	CRNA service, without medical direction by physician
SL	State supplied vaccine (Used for VFC administration codes only)
SG	Ambulatory Surgical Center (ASC) facility services
TC	Technical Component (required for laboratory and radiology services)
TF	Intermediate Level of Care (used **only** with procedure code T1029)

Modifier	Description
TG	Complex/high tech level of care (for use **only** with procedure codes 99231-99233, inpatient newborn care, for dates of service January 1, 2005 and after, and with procedure code T1029, Environmental Lead Assessment)
TF	Intermediate level of care (for use **only** with procedure code T1029)
TS	Follow-up Service (for use **only** with Case Management for Children and Youth program and for Case Management for Pregnant Women program)

The following additional level of care modifiers have been approved for use by Centers for Medicare and Medicaid Services to meet the needs of state Medicaid agencies and should not be submitted or used by any other payor.

Modifier	Description
U7	Sexual Assault Findings Examination (SAFE) and Child Abuse Resources Examination (CARE) exams
U8	Service provided in the home setting
U9	Diabetes Self-Management Training Services
UA	Lead related services
UC	EPSDT/HCY referral for follow-up care

SECTION 7
ADJUSTMENTS

Providers who are paid incorrectly for a claim should use the paper *Individual Adjustment Request* form to request an adjustment. Providers may also submit an individual adjustment via the Infocrossing Internet service, www.emomed.com, by using the claim frequency type option 7 for a replacement or option 8 for a void. Adjustments may not be requested when the net difference in payment is less than $4.00, or $.25 for pharmacy, per claim. If the adjustment is due to an insurance payment, or involves Medicare, the $4.00, or $.25, minimum limitation does not apply.

In some instances, more than one change may be necessary on a claim. **All** the changes to the claim must be addressed on the same *Individual Adjustment Request* form. Specify all the necessary changes, listing each change separately. Field 15 of the form may be used to provide additional information. **Only one claim can be processed per *Individual Adjustment Request* form as each adjustment request can only address one particular claim.** A separate *Individual Adjustment Request* form must be completed for each claim that requires changes, even if the changes or errors are of a similar nature or are for the same patient.

When using the Infocrossing Internet service to replace a paid claim using claim frequency type option 7, each line of the original paid claim must be re-entered even though a certain line or lines may not require an adjustment. A reprocessed Internet claim will have an ICN that begins with a “49”. Claim frequency type 8 is to be used only to void a previously paid claim and the payment is to be recouped. Claims voided through the Internet will appear on the next remittance advice with an ICN beginning with a “70”.

Providers submitting adjustment requests for changes in type of service codes or procedure codes must provide documentation for these changes. A copy of the original claim and the medical or operative report must be attached, along with any other information pertaining to the claim.

If an adjustment filed on paper does not appear on a Remittance Advice within 90 days of submission, a copy of the original *Individual Adjustment Request* and any attachments should be resubmitted. Photocopies are acceptable. Mark this copy with the word “Tracer”. Submitting another request without indicating it as a “tracer” can further delay processing. Adjustments for claim credits submitted via the Internet get a confirmation back the next day after submission to confirm the acceptance and indicate the status of the adjustment. If the Internal Control Number (ICN) on the credit adjustment is not valid, the confirmation file indicates such. If no confirmation is received, the provider should resubmit the claim credit.

See Section 4 of the Medicaid *Provider Manual* for timely filing requirements for adjustments and claim resubmissions. *Individual Adjustment Request* forms are to be submitted to the address shown on the form.

A sample Individual Adjustment Request is shown on the following page.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
MISSOURI MEDICAID

INDIVIDUAL ADJUSTMENT REQUEST

☐ UNDERPAYMENT ☑ OVERPAYMENT

TO FACILITATE PROCESSING, PLEASE ATTACH THE FOLLOWING:
1. Claim Copy
2. Remittance Advice Copy

FORWARD ORIGINAL TO:
ATTENTION: ADJUSTMENT UNIT
DIVISION OF MEDICAL SERVICES
P O BOX 6500
JEFFERSON CITY MO 65102

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE:

3. INTERNAL CONTROL NUMBER 1503225192499	6. RECIPIENT NAME Nelson, Harriett
4. RECIPIENT MEDICAID NUMBER 12345678	7. REMITTANCE ADVICE DATE 08/22/2003

5. PROVIDER LABEL
Scott, David 200000000
486 Doctors Lane
Medical City, MO 60000

8. R.A. PAGE NUMBER
7

REFER TO PROVIDER MANUAL ADJUSTMENT SECTION FOR INSTRUCTIONS

	SERVICE DATE	INFORMATION ON REMITTANCE ADVICE	CORRECTED INFORMATION
8. QTY/UNITS			
9. NDC/PROCEDURE CODE			
10. SERVICE DATE(S)			
11. BILLED AMOUNT			
12. PAID AMOUNT	08/04/2003	$24.00	$0.00
13. PATIENT SURPLUS			
14. OTHER RESOURCES (TPL) (IDENTIFY SOURCE)			

15. OTHER/REMARKS
Billed Medicaid in error. Please take back payment.

HELPFUL HINTS FOR FILING AN ADJUSTMENT REQUEST FORM

1. **Only one Internal Control Number (ICN) is allowed per adjustment request.**
2. **If you want Medicaid to recoup an entire payment, do *not* enter each line of the claim. Instead, complete the top of the form and line 12 only. Enter the date of service, the amount Medicaid paid and a "0" in the corrected information field.**
3. **When a change to a claim is necessary, such as a service date or quantity, use the ICN of the claim which paid and file an adjustment request. Do *not* send a new claim as it will deny as a duplicate.**
4. **An ICN beginning with a 70 or 75 credits or recoups the original paid claim; an ICN beginning with a 50 or 55 repays the claim with the corrected payment information.**
5. **Use the "Remarks" section of the adjustment request form to explain the reason for the correction.**

16. PROVIDER'S SIGNATURE	TITLE	DATE
		09/30/2003

MO 886-1019E (4-96)

MO 8810

SECTION 8
HEALTHY CHILDREN AND YOUTH PROGRAM

The Healthy Children and Youth (HCY) Program in Missouri is a comprehensive, primary and preventive health care program for Medicaid eligible children and youth under the age of 21 years in covered eligibility groups. The program is also known as Early Periodic Screening, Diagnosis and Treatment (EPSDT). Medicaid covers any physical or mental illness identified by the HCY screen regardless of whether the services are covered under the state Medicaid plan. Services that are beyond the scope of the Medicaid state plan may require a plan of care identifying the treatment needs of the child with regard to amount, duration, scope and prognosis. A Prior Authorization (PA) may be required for some services.

When the initial application for public assistance is made, all qualified applicants (or his/her guardian) under age 21 are informed of the HCY program. However, it is advisable for providers to notify their patients when HCY screenings are due in accordance with the following periodicity schedule:

Newborn (2-3 days)	15-17 months	8-9 years
By 1 month	18-23 months	10-11 years
2-3 months	24 months	12-13 years
4-5 months	3 years	14-15 years
6-8 months	4 years	16-17 years
9-11 months	5 years	18-19 years
12-14 months	6-7 years	20 years

FULL SCREENING

A full screen must be performed by an enrolled Medicaid physician, nurse practitioner or nurse midwife *(only infants age 0-2 months and females age 15-20 years)* and must include all of the components listed below. If all of the components are not included, a provider cannot bill for a full screen and is to bill only for a partial screen.

- Interval History
- Unclothed Physical Examination
- Anticipatory Guidance
- Lab/Immunizations (Lab and administration of immunizations is reimbursed separately)
- Lead Assessment (Provider must use the *HCY Lead Risk Assessment* form)
- Development Personal-Social and Language
- Fine Motor/Gross Motor Skills
- Hearing
- Vision
- Dental

It is mandatory that the age appropriate *HCY Screening Guide* be used to document all that components of a full or partial screen are met. The *HCY Screening Guide* is not all-inclusive; it is to be used as a guide to identify areas of concern for each component of the HCY screen. Other pertinent information can be documented in the comment fields of the guide. **The screener must sign and date the guide and retain it in the patient's medical record.** *HCY Screening Guides* can be obtained by using the *Forms Request* in Section 19 of this document or by downloading from the Internet at www.dss.mo.gov/dms.

Note: A provider cannot bill for an office visit and an HCY screen on the same date of service for a patient unless documentation in the medical record indicates a medical need for the office visit. The provider must include a "Certificate of Medical Necessity" with the claim when submitting it for payment.

DIAGNOSIS CODE FOR FULL OR PARTIAL SCREEN

Providers must use V20.2 as the primary diagnosis on claims for HCY screening services.

FULL SCREENING PROCEDURE CODES (New Patient)

Procedure Code (Use Age Appropriate Code)	Modifier 1	Modifier 2	Fee
99381*	21	EP	$60.00
99382*	21	EP	$60.00
99383*	21	EP	$60.00
99384*	21	EP	$60.00
99385*	21	EP	$60.00

FULL SCREENING PROCEDURE CODES (Established Patient)

Procedure Code (Use Age Appropriate Code)	Modifier 1	Modifier 2	Fee
99391*	21	EP	$60.00
99392*	21	EP	$60.00
99393*	21	EP	$60.00
99394*	21	EP	$60.00
99395*	21	EP	$60.00

Modifier "UC" must be used if child was referred for further care as a result of the screening. Modifier "UC" must always appear as the last modifier.

PARTIAL SCREENING

Different providers may provide segments of the full medical screen. The purpose of this is to increase the access to care for all children and to allow providers reimbursement for those separate screens. When expanded HCY services are accessed through a partial or interperiodic screen, it is the responsibility of the provider completing the partial screening service to have a referral source to refer the child for the remaining components of a full screening service.

An unclothed physical and history screen (CPT codes 99381EP-99385EP and 99391EP-99395EP) includes the first five sections of the age appropriate screening guide including:

- Interval history;
- Unclothed physical exam;
- Anticipatory guidance;
- Laboratory/Immunizations; and
- Age appropriate lead screening. Federal regulations require a mandatory blood lead testing by either capillary or venous method at 12 months and 24 months regardless of age. The provider must use the *HCY Lead Risk Assessment* form.

PARTIAL SCREENING PROCEDURE CODES – UNCLOTHED PHYSICAL & HISTORY (New Patient)
(Provider must complete Sections 1-5 of the HCY Screening Guide)

Procedure Code (Use Age Appropriate Code)	Modifier 1	Fee
99381*	EP	$20.00
99382*	EP	$20.00
99383*	EP	$20.00
99384*	EP	$20.00
99385*	EP	$20.00

PARTIAL SCREENING PROCEDURE CODES – UNCLOTHED PHYSICAL & HISTORY (Established Patient)
(Provider must complete Sections 1-5 of the HCY Screening Guide)

Procedure Code (Use Age Appropriate Code)	Modifier 1	Fee
99391*	EP	$20.00
99392*	EP	$20.00
99393*	EP	$20.00
99394*	EP	$20.00
99395*	EP	$20.00

Modifier "UC" must be used if child was referred for further care as a result of the screening. Modifier "UC" must always appear as the last modifier.

PARTIAL SCREENING CODES – DENTAL

Procedure Code	Modifier 1	Modifier 2	Fee
99429			$20.00
99429	UC		$20.00

PARTIAL SCREENING CODES – DEVELOPMENTAL/MENTAL HEALTH

Procedure Code	Modifier 1	Modifier 2	Fee
99429	59		$15.00
99429	59	UC	$15.00

PARTIAL SCREENING CODES – HEARING

Procedure Code	Modifier 1	Modifier 2	Fee
99429	EP		$5.00
99429	EP	UC	$5.00

PARTIAL SCREENING CODES – VISION

Procedure Code	Modifier 1	Modifier 2	Fee
99429	52		$5.00
99429	52	UC	$5.00

DESCRIPTION OF MODIFIERS USED FOR HCY SCREENINGS

- **EP -** Service provided as part of Medicaid/MC+ early periodic, screening, diagnosis, and treatment (EPSDT).
- **21 -** Prolonged evaluation and management services. Modifier 21 must be used when completing a full HCY screen to include all ten components.
- **52 -** Reduced services. Modifier 52 must be used when all the components for the unclothed physical and history procedure codes (99381-99395) have not been met according to CPT. Also used with procedure code 99429 to identify that the components of a partial HCY vision screen have been met.
- **59 -** Distinct Service. Modifier 59 must be used to identify the components of an HCY screen when only those components related to developmental and mental health are being screened.
- **UC -** EPSDT Referral for Follow-Up Care. The modifier UC must be used when the child is referred on for further care as a result of the screening. The modifier UC must always appear as the last modifier on the claim.

NEWBORN EXAMINATIONS

Initial newborn examinations have been identified as HCY screenings and providers **must** use either procedure code 99431 or 99432. When billing for either of these codes, field 24h on the CMS-1500 form **must** be marked with an "E." This indicates an EPSDT/HCY exam. The newborn's medical record must document that **the billing provider performed all components of a full HCY examination appropriate to the child's age and circumstances**.

DENTAL EXAMINATIONS

When a child receives a full HCY medical screen, it includes an oral examination that is **not** a full dental exam. A referral to a dental provider must be made where medically indicated when the child is under the age of one year. When the child is one year or older, a referral must be made, at a minimum, according to the dental periodicity schedule. Providers can tell the patient to use the DMS Internet web page, http://dss.mo.gov/dms/recipients.htm, to search for an enrolled dental provider in their area or other area of the state. On the web page, the patient should click on the "Medicaid Provider Search" link and follow the instructions.

IMMUNIZATIONS

HCY screening providers are responsible for giving required immunizations. Immunizations are recommended in accordance with guidelines of the Advisory Committee on Immunization Practices (ACIP). Immunizations must be provided during a full medical HCY screening unless medically contraindicated or refused by the parent or guardian of the patient. When an appropriate immunization is not provided, the patient's medical record must document why the appropriate immunization was not provided.

Providers must use the free vaccine provided by the Missouri Department of Health and Senior Services through the Vaccine for Children (VFC) program. To receive the free vaccine, providers must be enrolled with the Department of Health and Senior Services. Additional information on the VFC program appears later in this section.

LEAD SCREENING AND TREATMENT

All children ages six months to 72 months must be verbally assessed for lead poisoning using the questions contained in the *HCY Lead Risk Assessment Guide* (use Forms Request in Section 19 to order or download the Guide from the Internet at www.dss.mo.gov/dms). The *HCY Lead Risk Assessment* Guide is designed to allow the same document to follow the child for all visits from 6 months to 72 months of age. The guide has space on the reverse side to identify the type of blood test, venous or capillary; and also has space to identify the dates and results of blood lead levels. When an answer to any verbal question is "yes", a blood lead test must be done at that time.

Risk is determined from the response to the questions on the *HCY Lead Risk Assessment Guide*. The verbal risk assessment determines whether the child is low risk or high risk.

- If the answers to all questions are negative, a child is considered low risk for high doses of lead exposure.
- If the answer to any question is positive, a child is considered high risk for high doses of lead exposure and must receive a blood lead test.
- Blood level testing is mandatory at ages 12 and 24 months regardless to the response of the verbal assessment or where a child resides.

Providers must use Medicaid's *HCY Lead Risk Assessment Guide* and retain it in the patient's medical record.

For additional information on HCY/EPSDT, providers should reference Section 9 of the Medicaid *Provider Manual* at www.dss.mo.gov/dms.

PREVENTIVE MEDICINE FOR CHILDREN

Two of the key components of preventive medicine codes 99381-99395 are the history and unclothed physical examination. When an unclothed physical exam and history is performed for a recipient under the age of 21 years, providers should bill one of the appropriate HCY screening codes referenced on previous pages.

When all the components for the history and unclothed physical examination have not been met according to CPT, providers must bill one of the codes referenced in the chart below. CPT codes 99381-99395 cannot be billed alone without a modifier for a patient under the age of 21 years.

PREVENTIVE MEDICINE CODES – REDUCED- (New Patient)

Procedure Code (Use Age Appropriate Code)	Modifier 1	Modifier 2	Fee
99381	52	EP	$23.00
99382	52	EP	$23.00
99383	52	EP	$23.00
99384	52	EP	$23.00
99385	52	EP	$23.00

PREVENTIVE MEDICINE CODES – REDUCED – (Established Patient)

Procedure Code (Use Age Appropriate Code)	Modifier 1	Modifier 2	Fee
99391	52	EP	$15.00
99392	52	EP	$15.00
99393	52	EP	$15.00
99394	52	EP	$15.00
99395	52	EP	$15.00

SCHOOL PHYSICALS

A physical examination may be necessary in order to obtain a physician's certificate stating that a child is physically able to participate in athletic contests at school. When

this is necessary, diagnosis code V20.2 should be used. This also applies for other school physicals when required as conditions for entry into or continuance in the educational process. Use the appropriate Preventive Medicine code and modifiers listed in the above tables.

WELL WOMAN EXAMINATION

A well woman exam for a female patient 18-20 years of age can be billed using the age appropriate preventive medicine code and modifiers with diagnosis code V72.31.

SAFE/CARE EXAMINATIONS

Sexual Assault Findings Examination (SAFE) and Child Abuse Resource Education (CARE) examinations and related laboratory studies that ascertain the likelihood of sexual or physical abuse performed by SAFE trained providers certified by the Department of Health and Senior Services are covered by Medicaid. Children enrolled in a managed health care plan receive SAFE-CARE services as a benefit outside of the health plan on a fee-for-service basis. Additional information on SAFE-CARE examinations can be referenced in Section 13.15 of the physician manual located on the Internet at: www.dss.mo.gov/dms.

SAFE/CARE EXAM PROCEDURE CODES

Procedure Code	Modifier 1	Modifier 2	Fee
99205	U7		$187.50
99205	U7	52	$72.50

VACCINES FOR CHILDREN (VFC) PROGRAM

Through the VFC Program, federally provided vaccine is available at no charge to public and private providers for Medicaid eligible children ages 0 through 18 years.

Medicaid requires providers who administer immunizations to qualified Medicaid eligible children to enroll in the VFC program. The VFC program is administered by the Department of Health and Senior Services. Providers should contact the DOH as follows:

Missouri Department of Health and Senior Services
Section for Communicable Disease Prevention
Vaccines for Children Program
P.O. Box 570
Jefferson City, MO 65102
(800) 219-3224, (573) 526-5833

Medicaid will pay an administration fee per dose to providers to administer the free vaccine **except** to those providers enrolled as Rural Health Clinics (RHCs) or Federally Qualified Health Clinics (FQHCs). RHCs and FQHCs may bill an encounter code or appropriate level Evaluation and Management code if a medically necessary evaluation and management service is provided in addition to the VFC vaccine.

Immunizations for MC+ Recipients

MC+ health plans and their providers must use the VFC vaccine for Medicaid eligible MC+ health plan recipients. Plan providers must enroll in the program through the Department of Health and Senior Services. Providers should contact the appropriate MC+ health plan for proper billing procedures.

Immunizations Given Outside the VFC Guidelines

If an immunization is given to a Medicaid recipient who does not meet the VFC guidelines, use the standard procedure for billing injections. Physicians, clinics, and advanced practice nurse prescribers must bill injections on the Pharmacy Claim Form using the National Drug Code (NDC). The provider may bill either procedure code 90471 or 90472 for the administration of the immunization if that is the only service provided. If a significant, separately identifiable Evaluation and Management (E&M) service (codes 99201-99215) is performed, the appropriate E&M code may be billed in addition to the administration code.

The administration procedure codes may not be billed by federally qualified health centers (FQHCs) or rural health clinics (RHCs) as outlined by federal guidelines. The administration of any medications, including immunizations, is included in the encounter rate and additional reimbursement is not allowed.

FQHCs and provider based RHCs bill the CPT code for the appropriate immunization. Independent RHCs bill the encounter procedure code T1015 or T1015EP, which includes all services provided during the encounter.

VFC ADMINISTRATION CODES

Providers must use the SL modifier for the following VFC administration codes.

VACCINE FAMILY	VACCINE NAME	PRODUCT NAME	CPT CODE	MEDICAID ALLOWABLE
DTaP	DTaP	Infanrix	90700SL	$15.00
		DAPTACEL		
		Tripedia		
DT	DT		90702SL	$10.00
Td	Td, Preservative Free	DECAVAC	90714SL	$10.00
	Td		90718SL	$10.00

VACCINE FAMILY	VACCINE NAME	PRODUCT NAME	CPT CODE	MEDICAID ALLOWABLE
Tdap	Tdap	BOOSTRIX ADACEL	90715SL	$15.00
Polio	EIPV	IPOL	90713SL	$5.00
Hepatitis B	Hepatitis B	Engerix B Recombivax HB	90744SL	$5.00
Hepatitis A	Hepatitis A	Havrix VAQTA	90633SL	$5.00
Hib	Hib	PedvaxHIB	90647SL	$5.00
		ActHIB	90648SL	$5.00
		HibTITER	90645SL	$5.00
Influenza	Influenza (injectable)	Influenza, Preservative Free	90655SL	$5.00
		Influenza	90657SL	$5.00
		Influenza	90658SL	$5.00
	Influenza, live attenuated	FluMist	90660SL	$5.00
Meningococcal	Meningococcal	Menactra	90734SL	$5.00
MMR	MMR	MMRII	90707SL	$15.00
Pneumococcal	Pneumococcal 7-valent (Conjugate)	Prevnar	90669SL	$5.00
	Pneumococcal 23-valent (Polysaccharide)	Pneumovax 23 Pnu-Immune 23	90732SL	$5.00
Varicella	Varicella	Varivax	90716SL	$5.00
DTaP and Hib	DTaP/Hib	TriHIBit	90721SL	$20.00
DTaP, Hepatitis B, and Polio	DTaP/HB/IPV	Pediarix	90723SL	$25.00
Hepatitis B and Hib	Hepatitis B/Hib	COMVAX	90748SL	$10.00
Hepatitis A and Hepatitis B	Hepatitis A/ Hepatitis B 18	Twinrix	90636SL	$10.00
MMR and Varicella	MMRV	ProQuad	90710SL	$20.00

SECTION 9
MATERNITY CARE AND DELIVERY

GLOBAL POLICIES

The global prenatal/delivery/postpartum fee is reimbursable when one physician or physician group practice provides all the patient's obstetric care. For this purpose, a physician group is defined as an obstetric clinic, provider type "50", there is one patient record and each physician/nurse practioner/nurse midwife seeing that patient has access to the same patient record and makes entries into the record as services occur. A primary care physician is responsible for overseeing patient care during the patient's pregnancy, delivery, and postpartum care. The clinic may elect to bill globally for all prenatal, delivery, and postpartum care services provided with the clinic, using the primary care physician's provider number as the performing provider.

Global prenatal care includes all prenatal visits performed at medically appropriate intervals up to the date of delivery, routine urinalysis testing during the prenatal period, care for pregnancy related conditions (e.g. nausea, vomiting, cystitis, vaginitis), and the completion of the *Risk Appraisal for Pregnant Women* form. Only one prenatal care code, 59425 (four-six visits) or 59426 (seven or more visits), may be billed per pregnancy. The date of the delivery is the date of service to be used when billing the global prenatal codes. If a provider does more than three visits but the recipient goes to another provider for the rest of her pregnancy, all visits must be billed using the appropriate office visit procedure codes.

Billing for global services cannot be done until the date of delivery.

EXEMPTED VISITS/CONSULTATIONS

A total of two visits may be reimbursed by Medicaid to the initial provider (who is not the provider of ongoing care) to establish a pregnancy, perform an initial examination, and make a referral to a second provider. For example, many recipients utilize the services of a local health agency to establish their pregnancy which then refers them elsewhere for continuing care for their pregnancy. Therefore, if the recipient sees another provider for no more than two visits for her pregnancy, the provider of ongoing care is allowed to bill global.

In addition, two consultations may be reimbursed by Medicaid to another provider. The referring provider may still bill global.

RISK APPRAISAL - CASE MANAGEMENT

As part of the global prenatal/delivery requirements, providers must complete the *Risk Appraisal for Pregnant Women* form. No additional reimbursement will be paid for the completion of the form. Any eligible woman who meets any of the risk factors listed on the form is eligible for case management for pregnant women services and should be referred to a Medicaid enrolled participating case management provider.

NOTE - If you are not billing any of the global prenatal/delivery codes and you complete the *Risk Appraisal for Pregnant Women* form, you may bill for completion of the form using procedure code H1000.

The risk appraisal should be done during the initial prenatal visit or any time after the initial appraisal of a patient originally determined not to be at risk when changes in the patient's medical condition indicate the need.

GLOBAL OB CODES

Code	Description	Medicaid Allowable
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and or forceps), and postpartum care.	$1,075.00
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	$1,125.00
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps), and post partum care, after previous cesarean delivery	$1,075.00
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	$1,125.00
59425	Antepartum care only, 4-6 visits	$525.00
59426	Antepartum care only, 7 or more visits	$525.00

Billing Tip - To avoid a denial for global delivery code 59400, 59510, 59610, or 59618, if the recipient has more than two visits, you can bill the antepartum code, 59425 or 59426, plus the appropriate delivery code. If the recipient has more than two visits, only the global antepartum will be denied.

Medicaid providers have the option to bill OB services either globally or by individual dates of service. In order to bill globally, all Medicaid guidelines must be met.

OTHER DELIVERY CODES

Code	Description	Medicaid Allowable
59410	Vaginal delivery (with or without episiotomy, and/or forceps) including postpartum care	$550.00
59409	Vaginal delivery only (with or without episiotomy, and/or forceps), no post partum care	$440.00

Code	Description	Medicaid Allowable
59430	Postpartum care only (separate procedure), vaginal delivery	$110.00
59430	Postpartum care only (separate procedure)	$110.00
59515	Cesarean delivery including postpartum care	$600.00
59514	Cesarean delivery only, no post partum care	$480.00
59430	Postpartum care only (separate procedure), cesarean delivery	$110.00
59514-80	Assistant Surgeon, cesarean delivery	$120.00
59612	Vaginal delivery only, after previous cesarean delivery, (with or without episiotomy and/or forceps)	$440.00
59614	Vaginal delivery only, after previous cesarean delivery, with our without episiotomy and/or forceps), including postpartum care	$550.00
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery.	$480.00
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care	$600.00

OTHER BILLING REQUIREMENTS

- All claims with global and delivery procedure codes must show the date of the last menstrual period (LMP) in Field 14 on the CMS-1500 claim form.

- If billing a global delivery code or other delivery code, use a delivery diagnosis on the claim, e.g., 650, 669.70, etc.

- If billing a global prenatal code, 59425 or 59426, or other prenatal services, a pregnancy diagnosis, e.g., V22.0, V22.1, etc. is required on the claim.

QUESTIONS AND ANSWERS

The following are questions concerning global OB that are most frequently asked by providers and directed to the Medicaid staff.

Can Medicaid be billed by the same provider for the initial visit in the office for the pregnancy in addition to billing global?

No, all care related to the pregnancy is included in global. The only exception would be if the patient is under the age of 21 and a Healthy Children and Youth (HCY) screen was performed at the initial visit. If this is the case, the provider may bill the HCY screen using V20.2 for the primary diagnosis and a pregnancy diagnosis for the second diagnosis. Then as long as the provider meets all other global o.b. guidelines, the global o.b. codes may be billed as well.

Can the start up of a pitocin drip be billed separately?

No, Medicaid may not be billed for the start up of a pitocin drip. Not only is this procedure included in the global o.b. billing, it is also included in the delivery code if not billing global.

Can obstetrical ultrasounds be billed separately?

Yes, you may bill for ultrasounds when the ultrasounds are medically necessary. Obstetrical ultrasounds are limited to three per calendar year per recipient. If more than three are necessary, the claim must be accompanied by a properly completed Medical Necessity Form documenting the necessity of the procedure. Only one ultrasound is allowed per day. If it is medically necessary to perform a repeat ultrasound on the same day, refer to the CPT for follow-up or repeat procedures.

If the Medicaid patient has received care for her pregnancy by a provider on three different occasions, can another provider still bill global if they have met all the global guidelines?

No, the recipient is allowed two visits to a provider to establish the pregnancy and obtain a referral. If more than two visits to another provider have been reimbursed by Medicaid, the provider of ongoing care must bill out all services separately, i.e., office visits, each urinalysis, hospital visits, delivery, etc.

WILL YOUR PATIENT BE IN A MC+ HEALTH PLAN?

Depending on the area of the state, it is quite possible many of your patients may be required to enroll in a MC+ health plan and choose a primary care provider. Once a patient is enrolled in a MC+ health plan, payment for covered services becomes the responsibility of the health plan. Providers are encouraged to contact health plans to become enrolled as a MC+ provider with the plans.

If a patient becomes enrolled in a MC+ health plan in her third trimester of pregnancy, she may elect to continue to receive her obstetrical services from an out-of-plan provider. The out-of-plan provider must contact the appropriate health plan for instructions. If the out-of-plan provider only has admitting privileges in an out-of-plan hospital, the health plan is obligated to negotiate with the hospital on an agreeable reimbursement schedule.

When a patient receives more than two prenatal visits in a fee-for-service setting and transitions into a MC+ health plan and changes providers, neither provider may bill for a global OB service. In this situation, both providers must bill for each date of service using the appropriate CPT code.

When the obstetrical care begins as fee-for-service and continues with the same provider into a MC+ health plan, the provider must bill for date specific services for each program (Missouri Medicaid and the MC+ health plan). The provider cannot submit a claim for global OB care to either program.

TEMPORARY MEDICAID DURING PREGNANCY (TEMP), MEDICAL ELIGIBILITY (ME) CODE 58 OR 59

The purpose of the Temporary Medicaid During Pregnancy (TEMP) Program is to provide pregnant women with access to prenatal care while they await the formal determination of Medicaid eligibility.

TEMP services for pregnant women are limited to ambulatory physician, clinic, nurse-midwife, diagnostic laboratory, x-ray, pharmacy, and outpatient hospital services. Services other than those listed above may be covered with the attachment of a *Certificate of Medical Necessity* that testifies that the pregnancy would have been adversely affected without the service.

The diagnosis on the claim form **must** be a pregnancy/prenatal diagnosis (V22.0 through V23.9 or V28 through V28.9). Nurse midwives must use diagnosis codes V22.0 through V22.2 or V28 through V28.9.

Inpatient hospital services and deliveries performed either inpatient or outpatient are *not* covered under the TEMP program. Other non-covered services include postpartum care; contraceptive management; D & C; treatment of spontaneous, missed abortions or other abortions.

Infants born to mothers who are eligible under the TEMP Program are **not** automatically eligible under this program.

ABORTIONS AND MISCARRIAGES

Missouri Medicaid does **not** cover elective abortion services.

Any claim with a diagnosis of miscarriage, or missed or spontaneous abortion, diagnosis codes 632, 634.00-634.92, 635.00-635.92, 636-636.92 and 639-639.9, must be submitted on a paper CMS-1500 claim form with all appropriate documentation attached. The documentation should include the operative report, an ultrasound, the pathology report, the admit and discharge summary, etc. to show that this was not an elective abortion. If no ultrasound was performed, the reason for not performing it must be clearly documented in the patient's medical record.

The above information is required also when submitting a claim with one of the following CPT codes: 59200, 59812, 59821, 59830,

CPT codes 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, and 59866 also require a completed *Certificate of Medical Necessity for Abortion* form in addition to the previously noted documents.

SECTION 10
FAMILY PLANNING SERVICES

Family planning is defined as any medically approved diagnosis, treatment, counseling, drug, supply, or device prescribed or furnished by a provider to individuals of child-bearing age to enable such individuals to freely determine the number and spacing of their children.

When billing family planning services, providers must:

- Use a diagnosis code in the range of V25 through V25.9; and
- Enter "FP" in field 24H on the CMS-1500 or the appropriate field if billing electronically.

COVERED SERVICES

A provider may bill as a family planning service the appropriate office visit code which includes one or more of the following services.

- Obtaining a medical history
- A pelvic examination
- The preparation of smears such as a Pap Smear
  Note: Obtaining a specimen for a Pap smear is included in the office visit. Screening and interpretation of a Pap smear can be reimbursed only to a clinic or certified independent laboratory employing an approved pathologist, or to an individual pathologist.
- A breast examination
- All laboratory and x-ray services provided as part of a family planning encounter are payable as family planning services.
- A pregnancy test would be family planning related if provided at the time at which family planning services are initiated for an individual, at points after the initiation of family planning services where the patient may not have properly used the particular family planning method, or when the patient is having an unusual response to the family planning method.
- HIV blood screening testing performed as part of a package of screening testing and counseling provided to women and men in conjunction with a family planning encounter is reimbursable as a family planning service.

COPPER INTRAUTERINE DEVICE (IUD) (PARAGARD T380 – A)

The fee for procedure code 58300 covers insertion of the IUD. Procedure code J7300, Intrauterine Copper Contraceptive, should be billed for the purchase of the IUD. A copy of the invoice indicating the type and cost must be attached to the claim for manual pricing.

Code J7300 is to be used by physicians, nurse practioners, nurse midwives, federally qualified health centers (FQHCs) and provider based Rural Health Clinics (RHCs). A National Drug Code (NDC) should **not** be used to bill for the device.

The appropriate office visit procedure code may be billed for the removal of the IUD. (Procedure code 58301 is not a billable procedure as payment for the service is included in the office visit procedure code.)

LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (MIRENA)

Physicians, nurse practitioners, and nurse midwives must bill for the system on the Pharmacy Claim form using the National Drug Code (NDC).

FQHCs and Provider Based RHCs bill using procedure code J7302.

DIAPHRAGMS OR CERVICAL CAPS

The fitting of a diaphragm or cervical cap is included in the fee for an office visit procedure code. The cost of the diaphragm can be billed using procedure code A4266. The cost of the cervical cap can be billed using procedure code A4261. An invoice indicating the type and cost of the items must be sent with claims for these services for manual pricing.

NORPLANT SYSTEM

The following procedure codes are for insertion only, removal only, or removal with reinsertion only and do not include reimbursement for the device.

11975 - insertion, implantable contraceptive capsules
11976 - removal, implantable contraceptive capsules
11977 - removal, implantable contraceptive capsules with reinsertion

All providers except FQHCs, provider-based RHCs, and hospitals (outpatient services) must bill the Norplant device on the Pharmacy Claim form using the package NDC number. FQHCs and provider-based RHCs must bill procedure code A4260 for the Norplant device.

An office visit code may not be billed in addition to any of the Norplant procedure codes.

VAGINAL RING

Physicians, nurse practitioners, and nurse midwives must bill for the item on the Pharmacy Claim form using the National Drug Code (NDC).

FQHCs and Provider Based RHCs bill using procedure code J7303.

DEPO-PROVERA INJECTIONS

Depo-Provera injections should be billed on the Pharmacy Claim Form using the National Drug Code (NDC). FQHCs and provider based RHCS bill the injection using the appropriate injection “J” code.

STERILIZATIONS

A *Sterilization Consent* form (a copy of the form is in the Forms section of this publication) is a required attachment for all claims containing the following procedure codes: 55250, 58600, 58605, 58611, 58615, 58670, and 58671. **The Medicaid recipient must be at least 21 years of age at the time the consent is obtained and be mentally competent.** The recipient must have given informed consent voluntarily in accordance with Federal and State requirements.

The *Sterilization Consent* form must be completed and signed by the recipient at least **31** days, but not more than **180** days, prior to the date of the sterilization procedure. There must be **30** days between the date of signing and the surgery date. The day after the signing is considered the first day when counting the 30 days. There are provisions for emergency situations (reference Section 10.2.E(1) of the *Medicaid Provider Manua*l available on the internet at www.dss.mo.gov/dms).

Essure - The Essure procedure is a new permanent birth control alternative without incisions into the abdomen and any sutures or long postoperative recovery period. Essure is a device that is inserted into each fallopian tube which once incorporated into the fallopian tube, causes a localized tissue reaction. The body tissue grows into the micro-inserts, blocking the fallopian tubes.

Missouri Medicaid covers the Essure procedure in the inpatient or outpatient hospital setting only with procedure code 58565. The *Sterilization Consent* form must be completed and signed at least 30 days prior to the sterilization.

SERVICES FOR WOMEN FOLLOWING THE END OF PREGNANCY - MEDICAL ELIGIBILITY (ME CODE 80)

Services for medical eligibility code “80" are limited to family planning, and testing and treatment of Sexually Transmitted Diseases (STDs) and are provided on a fee-for-service basis only. The treatments of medical complications occurring from the STD are **not** covered for this program. The co-pay requirement does not apply to ME code “80".

Women with ME Code 80 are not eligible for HCY benefits and procedure codes with the EP modifier designating an HCY service are not covered.

Covered Procedure Codes For ME “80"

Code	Description
A4260	Levonorgestrel (Norplant) (FQHC & provider-based RHC only)
A4261	Cervical cap (invoice required with claim)

A4266	Diaphragm (invoice required with claim)
J1055	Injection - Medroxyprogesterone acetate (Depo-Provera), 150 mg (FQHC & provider- based RHC only)
J7300	IUD (invoice required with claim) (FQHC and Provider Based RHC only)
J7302	Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 mg (FQHC and provider-based RHC only)
J7303	Contraceptive vaginal ring (FQHC and Provider Based RHC only)
J7304	Contraceptive hormone patch (FQHC and Provider Based RHC only)
Q0111	Wet mounts (PPMP CLIA List)
T1015	Rural health clinic encounter (independent RHC)
00400	Anesthesia for procedures on anterior integumentary system of chest including subcutaneous tissue
00851	Aesthesia for intraperitoneal procedure in lower abdomen including laparoscopy, tubal ligation/transection
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium
11975	Insertion Norplant
11976	Removal Norplant
11977	Removal with reinsertion - Norplant
58300	Insertion IUD
58565	Hysteroscopy, sterilization
58600	Ligation or transection of fallopian tubes
58605	Ligation or transection of fallopian tubes, postpartum
58611	Ligation or transection of fallopian tubes, at time of C-section
58615	Occlusion of fallopian tubes by device
58670	Laparoscopy with fulguration of oviducts
58671	Laparoscopy with occlusion of oviducts by device
99070	Supplies and materials over and above those usually included with office visit (requires invoice with claim)
99201-99215	Evaluation and management office/outpatient procedures (Do **not** use the EP modifier with these codes.)
99383-99387	Initial comprehensive preventive medicine (new patient) (Do **not** use the EP modifier with these codes.)
99393-99397	Periodic comprehensive preventive medicine (established patient) (Do **not** use the EP modifier with these codes.)
Lab procedures	Pap tests, tests to identify a STD, urinalysis, and blood work related to family planning or STDs.

Medically necessary diagnostic imaging

Covered Diagnosis Codes For ME “80"

V25-V25.9	Encounter For Contraceptive Mgt
V72.31	Gynecological Exam
V73.8-V73.88	Other Specified Viral and Chlamydial Diseases
V73.9-V73.98	Unspecified Viral and Chlamydial Disease
V74.5	Venereal Disease
054.1-054.19	Genital Herpes

091-091.2, 092-092.9	Syphilis
098-098.19	Gonococcal Infections
099-099.9	Other Venereal Diseases

Covered Birth Control Products

Progestational Agents	Contraceptives, Implantable
Contraceptives, Oral	Contraceptives, Injectable

Drugs Used To Treat STDs

Keratolytics	Aminoglycosides	Penicillins
Absorbable Sulfonamides	Vaginal Antifungals	Antifungal Agents
Probenecid	Tetracyclines	Vaginal Antibiotics
Topical Antiparasitics	Macrolides	Lincosamides
Topical Antivirals	Cephalosporins	Quinolones
Antivirals, General		

SECTION 11
SURGERY

PROCEDURE CODES

Missouri Medicaid recognizes the CPT and HCPCS surgery procedure codes and follows the code descriptions listed in the current editions of the publications when reviewing claims. Specific knowledge of the procedures and services performed by the physician is vital in assigning the proper CPT and HCPCS codes. Systems should be in place to correctly transmit information between the physician and the coder.

SURGICAL MODIFIERS

Missouri Medicaid uses the following CPT modifiers for surgical procedures.

50 - bilateral procedure
54 - surgical care only
55 - post operative management only
62 - two surgeons
80 - assistant surgeon
SG- Ambulatory Surgical Center only (facility services)

POST-OPERATIVE CARE

Post-operative care includes 30 days of routine follow-up care for those surgical procedures having a Medicaid reimbursement amount of $75.00 or more. For counting purposes, the date of surgery is the first day.

This policy applies whether the procedure was performed in the hospital, an ambulatory surgical center, or an office setting; and applies to subsequent physician visits in any setting (e.g., inpatient and outpatient hospital, office, home, nursing home, etc.).

Supplies necessary for providing follow-up care in the office, such as splints, casts and surgical dressings in connection with covered surgical procedures, may be billed under the appropriate office supply code. See Section 14 for the list of office supply codes.

INCIDENTAL/SEPARATE SURGICAL PROCEDURES

Surgeries considered incidental to, or a part of another procedure, performed on the same day, are **not** paid separately, but rather are included in the fee for the major procedure. Determine if the surgery is considered incidental by asking yourself if it is a necessary part of the surgery or was the surgery "incidentally" performed, e.g. a laparoscopy that precedes a laparotomy. For information on procedures that are not paid when incidental to other specified services, see Section 13.42 of the Medicaid *Physician Provider Manual*.

Separate procedures are defined as a service performed independently of, and is not immediately related to other services. When performed alone for specific and documented purposes, it may be reported. The procedure should not be billed unless it is performed by itself or is not immediately related to other services being performed during the same session.

MULTIPLE SURGICAL PROCEDURES

Multiple surgical procedures performed on the same recipient on the same date of service by the same provider for the same or separate body systems through separate incisions are to be billed out separately for each procedure. The important factor in coding multiple surgical procedures is to list the surgeries in order of importance or significance for payment, not necessarily always listing the most time consuming procedure first. Claims for multiple surgeries are reimbursed according to the following:

100% of the allowable fee for the major procedure
50% of the allowable fee for the secondary procedure
25% of the allowable fee for the third procedure

An operative report must always accompany claims with multiple surgical procedures on the same recipient on the same date of service.

ASSISTANT SURGEON

Missouri Medicaid adheres to guidelines set by Medicare services for assistants at surgery.

Information on Medicare's guidelines for assistant surgeons is found in the Medicare Services Newsletter, "Indicators/Global Surgery Percentages/Endoscopies", at http://www.momedicare.com/provider/provnewslet/newsindex.asp. You must accept the **License for Use of "Physicians' Current Procedural Terminology", Fourth Edition (CPT)** agreement at this website before the information can be viewed. The indicator assigned to each surgical code is found in column A of the Surgery Indicator Table.

Examples found in Column A include:

- Some procedures do not require an assistant surgeon (Assistants at surgery are never paid for these procedures.)
- Assistant at surgery is paid (No payment restriction applies.)
- Payment restriction for assistants at surgery applies; a *Certificate of Medical Necessity* form is required (These procedures do not normally require an assistant surgeon but with medical necessity will be considered for payment.)

Note - Not all codes in the listing are covered by Missouri Medicaid; refer to the Missouri Medicaid fee schedule at **www.dss.mo.gov/dms** for coverage information.

The medical necessity for the assistant at surgery must be fully documented on the C*ertificate of Medical Necessity* form. The form must include the assistant surgeon's name, provider number, and signature. Instructions for completing the *Certificate of Medical Necessity* form are in Section 7.2 of the Missouri Medicaid *Provider Manual.*

CO-SURGERY

"Co-Surgeons" are defined as two primary surgeons working simultaneously performing distinct parts of a total surgical service, during the same operative session. Each physician should submit separate claims, using his/her own individual/clinic Medicaid provider number. The surgical procedure code together with modifier "62" should be shown on both claims. The name of both surgeons must appear on the claim form in the "description" area (field 24d on the CMS-1500), with a description of the entire (total) procedure performed. An operative report must be attached to each claim and the operative report should justify the necessity of two surgeons. These claims cannot be billed electronically and are manually priced by the medical consultant.

CONSULTATIONS

A consultation is when a physician renders an opinion or advice at the request of another physician. It is **not** a referral of a patient to another physician for care and treatment. A consultation must always include a written report sent back to the requesting physician. The written report must include all findings, the opinion of the consulting physician, and advice or recommendations for patient treatment. When a consulting physician begins to "treat" rather than advise on treating, then it ceases to be a consultation. At that time, the consulting physician becomes an attending physician for the patient and should use appropriate levels of service codes based on the place of service.

CONSULTATION CODES

Office/Outpatient Consult Codes	In-patient Consult Codes
99241	99251
99242	99252
99243	99253
99244	99254
99245 (requires a copy of the consult report with the claim)	99255 (requires a copy of the consult report with the claim)

Follow-up inpatient consultations (CPT codes 99261-99263) are visits to complete the initial consultation or subsequent visits requested by the attending physician.

SECOND SURGICAL OPINION

The intent of the Second Surgical Opinion Program is to provide an eligible Missouri Medicaid patient with a second opinion as to the medical necessity of certain elective surgical operations. When the second opinion has been obtained, regardless of whether or not it confirms the primary recommendation for surgery, the final decision to undergo or forego elective surgery remains with the Medicaid patient. A list of the procedure codes requiring a second surgical opinion appears later in this section.

The Second Surgical Opinion form contains four sections and must be completed in the following manner:

Section I This section is completed by the physician recommending surgery. The appointment date in this section must be the date the patient was seen by the physician recommending surgery.

Section II Completed by the second opinion physician. A second opinion must be obtained within **60 days** after the primary recommendation appointment date in Section I of the form. When rendering a second opinion, the physician should bill a procedure code in the range of 99271-99274.

Section III Completed by the third opinion physician. A third opinion must be obtained within **60 days** after the second opinion appointment date in Section II. A third opinion is allowed by Missouri Medicaid if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation. When rendering a third opinion, the physician should bill a procedure code from the range 99271-99274.

Section IV Completed by the surgeon. Surgery must be performed within **150 days** of the first appointment date in Section I. Section IV should be completed and signed by the surgeon any time on or after the date of surgery. It is the surgeon's responsibility to furnish the hospital or ambulatory surgical center with a copy of the completed second opinion form.

Staff interns, residents, and nurse practioners are **not** permitted to provide the first, second, or third opinion.

Note – Anesthesiologists, assistant surgeons, independent laboratories, and independent x-ray services are exempt from the requirement to submit a copy of the Second Surgical Opinion form with a claim for services.

EXCEPTIONS TO SECOND OPINION REQUIREMENT

- Medicare/Medicaid crossover claims are exempt.
- The Second Surgical Opinion form is not required if the surgeon does not participate in the Missouri Medicaid Physician Program. This must be stated in field 19 of the CMS-1500 claim form and the physician's full name listed.
- Those surgical operations specified are exempt from the second surgical opinion
- requirement if any one of them is performed incidental to a more major surgical procedure that does not require a second surgical opinion.

- If the service was performed as an emergency and a second opinion could not be obtained prior to rendering the service, complete the claim form and enter "emergency" in field 19 of the CMS-1500. Attach a *Certificate of Medical Necessity* form (or other adequate documentation such as operative notes, admit or discharge summaries, etc.) to the claim. The provider must state on the *Certificate of Medical Necessity* form, in detail, the reason for the emergency provision of service.

- If the recipient was not eligible for Medicaid at the time of service, but was made retroactive to that time. If the provider is unable to obtain an eligibility approval letter from the recipient, the claim may be submitted with a completed *Certificate of Medical Necessity* form indicating the recipient was not eligible at the time of service but has become eligible retroactively to that date. (See Section 7 of the Missouri *Medicaid Provider* Manual for information on completing the *Certificate of Medical Necessity* form.) If the eligibility approval letter or the *Certificate of Medical Necessity* form is not submitted, the claim will be denied.

SURGERY CODES THAT REQUIRE A SECOND OPINION

Effective for dates of service July 1, 2005 and after, only the following six procedure codes require the submission of a Second Surgical Opinion form.

66840 - removal of lens material aspiration technique, one or more stages
66850 - removal of lens material phacofragmentation technique
66852 - removal of lens material; pars plana approach, with or without virectomy
66920 - removal of lens material; intracapsular
66983 - intracapsular cataract extraction with insertion of intraocular lens prosthesis- one stage procedure
66984 – extracapsular cataract removal with insert, intraocular lens prosthesis- one stage procedure, manual or mechanical technique.

The procedure codes on the following page require a second surgical opinion and the submission of a "Second Surgical Opinion" form for dates of service prior to July 1, 2005. Procedure codes marked with an "*" also require the submission of an "Acknowledgment of Hysterectomy Information" form.

28290
28290-50
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28292-6250
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28293-6250
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28296-50
28296-62
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28297-62
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51925*
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57260-62
57265
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58150*
58150-62*
58152*
58152-62*
58180*
58180-62*
58200*
58200-62*
58210*
58210-62*
58240*
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58260*
58260-62*
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66840
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66850-50
66852
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66852-62
66852-6250
66920
66920-50
66920-62
66920-6250
66983
66983-50
66984
66984-50

SECTION 12
ANESTHESIA

PROCEDURE CODES

Medicaid recognizes CPT anesthesia codes 00100 - 01999. The surgical procedure for which anesthesia services are being provided, must be a covered Medicaid service.

When the anesthesiologist or CRNA administers anesthesia for multiple surgical procedures for the same recipient on the same date of service during the same surgery, only the major procedure should be billed and the total number of minutes should be shown for all procedures.

Physicians and CRNAs may also bill for the insertion of intra-arterial lines, Swan Ganz catheters, central venous pressure lines, emergency intubation, and epidurals. These services are separately reportable when performed by the physician or CRNA using the following procedure codes. These codes should be billed **without** any modifier.

20550	36406	36660	62319	64415	64445	99100
31500	36410	36680	64400	64417	64450	99116
36000	36420	62273	64402	64418	64505	99135
36010	36425	62281	64405	64420	64508	99140
36011	36510	62282	64408	64421	64510	
36014	36600	62310	64410	64425	64520	
36400	36620	62311	64412	64430	64530	
36405	36625	62318	64413	64435	93503	

CPT Code 01996 (daily hospital management of epidural or subarachnoid continuous drug administration) is billed with a quantity of 1 and without any modifier.

SUPERVISION (MEDICAL DIRECTION)

Anesthesiologists must have a provider specialty of anesthesiology to bill for medical direction of qualified and licensed Anesthesiologist Assistants (AA) and CRNAs.

Anesthesiologists must supervise at least two, but not more than four anesthetists. When the anesthesiologist and anesthetist both are involved in a single anesthesia service (supervision of only one anesthetist), the service is considered to be personally performed by the anesthesiologist. No separate payment is allowed for the CRNA and a charge for supervision is inappropriate.

MODIFIERS

The following modifiers should be used for anesthesia services.

AA - Anesthesia services performed personally by anesthesiologist
QK - Medical direction of two, three or four concurrent procedures involving qualified individuals
QX - CRNA service, with medical direction by physician
QZ - CRNA service, without medical direction by physician

ANESTHESISA BILLING TIPS

- For paper claims with dates of service **prior** to October 16, 2003, bill the surgical procedure code with the appropriate modifier (AA, QK, QX or QZ) for the service. Do **not** use a type of service code.
- Administration of local infiltration, digital block, or topical anesthesia by the operating surgeon or obstetrician is included in the surgery fee, and a separate fee for administration should not be billed.
- Local anesthesia should not be reported separately. It is included in the procedure/surgery if provided in the physician's office; if provided in an Ambulatory Surgical Center (ASC) or outpatient department of the hospital, it is included in the facility charge; if provided on an inpatient basis, it is included in the accommodation revenue code for the facility.
- There may be an occasional need for anesthesia during CT scan or MRI services as a result of medically necessary circumstances, i.e., hyperactive child, mentally retarded individual, etc. To report this service, use procedure code 01922 (unlisted diagnostic radiologic procedure) with the appropriate modifier.
- Anesthesiologist monitoring telemetry in the operating room is non-covered.
- Routine resuscitation of newborn infants is included in the fee for the administration of the obstetrical anesthesia in low-risk patients.
- Anesthesiologist and CRNA services are not covered in the recovery room.
- Pain management is considered a part of postoperative care. However, if an epidural or intrathecal catheter is specifically inserted for pain management, it can be reimbursed. If already inserted for anesthesia, no separate payment is allowed.
- Many anesthesia services are provided under particularly difficult circumstances, depending on factors such as extraordinary condition of patient, notable operative conditions, or unusual risk factors. These procedures may be reported in addition to anesthesia services. The following procedures should be billed:

  99100 - Anesthesia for patient of extreme age, under one year and over seventy.
  99116 - Anesthesia complicated by utilization of total body hypothermia.
  99135 - Anesthesia complicated by utilization of controlled hypotension.
  99140 - Anesthesia complicated by emergency conditions (specify).

  When billing the above procedure codes, the maximum quantity is always "1" as reimbursement is based on a fixed maximum allowable amount.

SECTION 13
OFFICE MEDICAL SUPPLY CODES

Supplies and materials provided by the physician above those usually included with an office visit may be billed using the appropriate supply code.

PROC. CODE	DESCRIPTION
A4260	Levonorgestrel (Norplant) device only (FQHC and provider-based RHC only)
A4261	Cervical Cap for Contraceptive use (invoice required for pricing)
A4266	Diaphragm (invoice required for pricing)
A4300	Implantable Vascular Access Portal/Catheter (Venous, Arterial, Epidural or Peritoneal)
A4344	Indwelling Catheter, Foley Type, Two-Way, All Silicone
A4565	Slings
A4570	Splint
A4580	Cast Supplies
A4590	Casting (Fiberglass)
A4627EP	Spacer, Bag or Reservoir, with or without mask, for use with metered dose inhaler (invoice required for pricing)
J7300	Intrauterine Copper Contraceptive (Invoice required for pricing)
J7302	Levonorgestrel-Releasing Intrauterine Contraceptive System (Mirena) (for FQHC and provider-based RHC use only)
J7303	Vaginal Ring (for FQHC and provider-based RHC use only)
L0120	Cervical, Flexible, Non-Adjustable (Foam Collar)
L0140	Cervical, Semi-Rigid, Adjustable (Plastic Collar)
L1825	KO, Elastic Knee Cap
99070	Supplies and material (except eyeglasses, hearing aids) provided by the physician over and above those usually included with the office visit or other services rendered. (In Field 24D of the CMS-1500 claim form, list drugs, trays, supplies or materials provided.) (Invoice required for pricing)

SECTION 14
PRIOR AUTHORIZATION

Providers are required to seek prior authorization for certain specified services **before** delivery of the services. In addition to services that are available through the traditional Medicaid Program, expanded services are available to children 20 years of age and under through the Healthy Children and Youth (HCY) Program. Some expanded services also require prior authorization.

The following general guidelines pertain to all prior authorized services.

- A Prior Authorization (PA) Request **must** be completed and mailed to: Infocrossing Healthcare Services, Inc., P.O. Box 5700, Jefferson City, M0 65102. Providers should keep a copy of the original PA Request form, as the form is not returned to the provider.
- The provider performing the service **must** submit the PA Request form. Sufficient documentation or information **must** be included with the request to determine the medical necessity of the service.
- The service **must** be ordered by a physician, nurse practitioner, dentist, or other appropriate health care provider.
- Do **not** request prior authorization for services to be provided to an ineligible person. Authorization considers medical necessity only and does not examine eligibility.
- Expanded HCY (EPSDT) services are limited to recipients 20 years of age and under and are **not** reimbursed for recipients 21 and over even if prior authorized.
- Prior authorization does **not** guarantee payment if the recipient is or becomes enrolled in managed care and the service is a covered benefit.
- Payment is **not** made for services initiated before the approval date on the PA Request form or after the authorization deadline. For services to continue after the expiration date of an existing PA Request, a new PA Request **must** be completed and mailed.

Whether the prior authorization is approved or denied, a disposition letter will be returned to the provider containing all of the detail information related to the prior authorization request. Any other documentation submitted with the prior authorization request will not be returned with the exception of x-rays and dental molds. All requests for changes to an approved prior authorization should be indicated on the disposition letter and submitted to the same address as the original prior authorization request.

Instructions for completing the PA Request form are found in Section 8 of the Medicaid *Provider's Manual* available on the Internet at www.dss.mo.gov/dms.

PROCEDURES REQUIRING A PRIOR AUTHORIATION

The following procedure codes require a Prior Authorization Request form.

11920	15836	19364-50	21194	50365-6250*	67903-50
11920-EP	15837	19366	21230	50547	67903-62
11921	15838	19366-50	21235	50547-50	67903-6250
11921-EP	15839	19367	21260	50547-62	67904
11922-EP	17999-EP	19367-50	21260-62	50547-6250	67904-50
11960	19316	19368	21261	54152	67904-62
11970	19316-50	19368-50	21261-62	54161	67904-6250
11971	19318	19369	21720	54162	67906
11981	19318-50	19369-50	21725	54163	67906-50
11982	19324	19370	21725-62	54164	67908
11983	19324-50	19370-50	26580	56805	67908-50
15780	19325	19371	26590	56805-62	67909
15781	19325-50	19371-50	43644	57335	67909-50
15782	19328	19380	43645	57335-62	67923
15786	19328-50	19380-50	43659	58345	67923-50
15787	19330	20974	43659-50	58345-50	67924
15810	19330-50	21086	43842	58345-62	67924-50
15820	19340	21086-50	43842-62	58345-6250	69300
15820-50	19340-50	21087	43843	65767	69949-EP
15821	19342	21088	43843-62	65767-50	71250**
15821-50	19342-50	21120	43845	65780	71260**
15822	19350	21120-62	43846	65782	71270**
15822-50	19350-50	21121	43846-62	67900	71275**
15823	19355	21122	43847	67901	71550**
15823-50	19355-50	21123	43847-62	67901-50	71551**
15831	19357	21123-62	43848	67902	71552**
15832	19357-50	21125	43848-62	67902-50	71555**
15833	19361	21127	50365*	67902-62	92391-EP
15834	19361-50	21127-62	50365-50*	67902-6250	
15385	19364	21188	50365-62*	67903	

* This service requires a Division of Medical Services Transplant Contract.

** A Prior Authorization is not required if this service is provided in an inpatient hospital or emergency room setting.

SECTION 15
LABORATORY SERVICES

Missouri Medicaid follows Medicare guidelines for billing of professional and technical and total components of laboratory tests. Providers should reference Medicare's Newsletter for Indicators/Global Surgery/Percentages/Endoscopies at http://www.momedicare.com/.

Professional component only codes – Modifiers 26 and TC cannot be billed with these codes. Examples - 80500 and 85097.

Technical component only codes – Modifiers 26 and TC cannot be billed with these codes. Examples - 81002 and 82270.

Total component codes – These codes have a professional, technical, and total component. When billing for the professional component, use the 26 modifier. When billing for the technical component, use the TC modifier. When billing for the total component, do not use any modifiers. Examples - 88104, 88300.

Clinical Laboratory Improvement Act (CLIA)

CLIA WAIVER PROCEDURES

Medicaid providers possessing a "Certificate of Waiver" are allowed to perform the following procedures.

G0328	82274	83002	84478	86701
80061	82465	83026	84703	86703
80101	82570	83036	84830	87077
80178	82679	83037	85013	87210
81002	82271	83518	85014	87210U7
81003	82272	83605	85018	87449
81025	82947	83718	85576	87804
81025U7	82950	83721	85610	87807
82010	82951	83880	85651	87880
82044	82952	83986	86294	87899
82055	82962	84443	86308	89300
82120	82985	84450	86318	
82270	83001	84460	86618	

PHYSICIAN PERFORMED MICROSCOPY PROCEDURES (PPMP)

Medicaid providers possessing a PPMP certificate are allowed to perform all the waiver procedures as well as the following additional procedures.

Q0111	Q0113	Q0115	81001	81020	89190
Q0112	Q0114	81000	81015	89055	

Questions regarding CLIA registration or accreditation should be directed to:

Bureau of Health Facility Regulation
Department of Health and Senior Services
P.O. Box 570
Jefferson City, Missouri 65102-0570
(573) 751-6318

SECTION 16
RESOURCE PUBLICATIONS FOR PROVIDERS

CURRENT PROCEDURE TERMINOLOGY (CPT)

Missouri Medicaid uses the latest version of the *Current Procedural Terminology* (CPT). All provider offices should obtain and refer to the CPT book to assure proper coding. Providers can order a CPT book from the American Medical Association.

Order Department
American Medical Association
P.O. Box 7046
Dover, DE 19903-7046
Telephone Number: 800/621-8335
Fax Orders: 312/464-5600

ICD-9-CM

The *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9) is the publication used for proper diagnostic coding. The diagnosis code is a required field on certain claim forms and the accuracy of the code that describes the patient's condition is important. The publication can be ordered from the following source.

Ingenix Publications
P.O. Box 27116
Salt Lake City, UT 84127-0116
800/464-3649
Fax Orders: 801/982-4033
www.IngenixOnline.com

HEALTH CARE PROCEDURE CODING SYSTEM (HCPCS)

Medicaid also uses the *Health Care Procedure Coding System (HCPCS), National Level II*. It is a listing of codes and descriptive terminology used for reporting the provision of supplies, materials, injections and certain services and procedures. The publication can be ordered from the following.

Practice Management Information Corporation
4727 Wilshire Blvd. Ste 300
Los Angles, CA 90010
800/633-7467
http://pmiconline.com

SECTION 17
RECIPIENT LIABILITY
State Regulation 13CSR 70-4.030

If an enrolled Medicaid provider does not want to accept Missouri Medicaid as payment but instead wants the patient (recipient) to be responsible for the payment (be a private pay patient), there must be a written agreement between the patient and the provider in which the patient understands and agrees that Medicaid will not be billed for the service(s) and that the patient is fully responsible for the payment for the service(s). The written agreement must be date and service specific and signed and dated both by the patient and the provider. **The agreement must be done prior to the service(s) being rendered.** A copy of the agreement must be kept in the patient's medical record.

If there is no evidence of this written agreement, the provider cannot bill the patient and must submit a claim to Medicaid for reimbursement for the covered service(s).

If Medicaid denies payment for a service because all policies, rules and regulations of the Missouri Medicaid program were not followed (e.g., Prior Authorization, Second Surgical Opinion, etc.), the patient is not responsible and cannot be billed for the item or service.

All commercial insurance benefits must be obtained before Medicaid is billed.

MEDICAID RECIPIENT REIMBURSEMENT (MMR)

The Medicaid Recipient Reimbursement program (MMR) is devised to make payment to those recipients whose eligibility for Medicaid benefits has been denied and whose eligibility is subsequently established as a result of an agency hearing decision, a court decision based on an agency hearing decision, or any other legal agency decision rendered on or after January 1, 1986.

Recipients are reimbursed for the payments they made to providers for medical services received between the date of their denial and the date of their subsequent establishment of eligibility. The recipient is furnished with special forms to have completed by the provider(s) of service. If Medicaid recipients have any questions, they should call (800) 392-2161.

SECTION 18
FORMS

On the following pages are copies of various forms used by the Missouri Medicaid program.

Certain Medicaid programs, services, and supplies require the submission of a form before a claim can be processed for payment. Please note that several of the forms can be submitted electronically through the Infocrossing Internet service at www.emomed.com.

Acknowledgement of Receipt of Hysterectomy Information
Second Surgical Opinion
Sterilization Consent
Certificate of Medical Necessity (use the link at the CMS# 1500 claim line level)

If a form is submitted electronically, the provider **must** keep a paper copy of the form in the patient's medical record.

Copies of the forms are available from Medicaid from the following sources.

- Contact the Provider Communications Unit at 573/751-2896.
- Go to the Medicaid Web site, www.dss.mo.gov/dms/providers.htm, and select and click on "Medicaid Forms" on the left side of the Web page..
- Use the Infocrossing order form found at the end of this section.

MO-8812

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE.** I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ (Month Day Year)

I, _____, hereby consent

of my own free will to be sterilized by _____ (doctor)

by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date _____
Signature (Month Day Year)

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ _____
Interpreter Date

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____ _____
Signature of person obtaining consent *Date*

_____
Facility

_____
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

_____ , _____ ,
Name of individual to be sterilized *Medicaid number*

on _____ (Date of sterilization), I explained to him/her the nature of the sterilization operation _____ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested).

- ☐ Premature delivery
- ☐ Individual's expected date of delivery:
- ☐ Emergency abdominal surgery:

(describe circumstances):

_____
Physician

_____ _____
Medicaid provider number *Date*

PSFL - 200
(Revised 11/01/00)

MISSOURI DEPARTMENT OF HEALTH

RISK APPRAISAL FOR PREGNANT WOMEN

INSTRUCTIONS ON REVERSE SIDE

DCN OR TEMP. NO	BIRTHDATE (MM/DD/YY)	DATE OF RISK APPRAISAL	PROVIDER NAME (ATTACH MEDICAID PROVIDER LABEL)
CLIENT'S NAME (LAST, FIRST, MI, MAIDEN)			ADDRESS (STREET)
ADDRESS (STREET)			CITY STATE ZIP CODE
CITY STATE ZIP CODE			MEDICAID PROVIDER NUMBER / MONTH PRENATAL CARE BEGAN ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9
TELEPHONE NUMBER ( )	COUNTY OF RESIDENCE		MARITAL STATUS CODE ☐S ☐M ☐W ☐D ☐SEP

RACE/ETHNICITY	HISPANIC ORIGIN	LMP (MM/DD/YY)	GRAVIDA	PARA	ABORTA
☐1. WHITE ☐2. BLACK ☐3. AM.IND/ALASKAN ☐4. ASIAN/PACIFIC ISLANDER ☐5. OTHER _____	☐ YES ☐ NO				

PUT AN "X" IN ALL THE BOXES BELOW THAT APPLY. AN "X" IN ANY ONE OF THE FIRST 34 RISK FACTOR BOXES QUALIFIES CLIENT FOR CASE MANAGEMENT SERVICES.

☐ 1. Mother's age 17 years of less at time of conception.

☐ 2. Mother's education less than 8 years.

☐ 3. Gravida greater than or equal to 7.

☐ 4. Smoking equal to or greater than one pack of cigarettes per day, IF CLIENT HAS STOPPED SMOKING BY THE 12TH WEEK OF GESTATION, CONSIDER AS NON SMOKING.

☐ 5. Mother's age 40 years or greater at time of conception.

☐ 6. Prepregnancy weight less than 100 lbs.

☐ 7. Previous fetal death (20 weeks gestation or later).

☐ 8. Previous infant death.

☐ 9. History of incompetent cervix in current or past pregnancy.

☐10. History of diabetes mellitus including gestational diabetes in current or past pregnancy.

☐11. Multiple fetuses in current pregnancy.

☐12. Pre-existing hypertension (a history of hypertension — 140/90 mm Hg or greater — antedating pregnancy or discovery of hypertension — 140/90 or greater — before the 20th week of pregnancy).

☐13. Pregnancy-induced hypertension in current pregnancy (blood pressure is 140/90 or greater, or there has been an increase of 30 mm Hg systolic or 15 mm Hg diastolic over baseline values on at least two occasions six or more hours apart).

☐14. Prior low birth weight baby (<2500 grams or 5 lbs. 8 oz.).

☐15. Prior preterm labor (<37 completed weeks gestation).

☐16. Preterm labor: current pregnancy.

☐17. Seropositive for HIV antibodies.

☐18. Interconceptional spacing <1 year.

☐19. Living alone or single parent living alone.

☐20. Considered relinquishment of infant.

☐21. Poor environmental conditions.

☐22. Late entry into care (after 4th month or 18 weeks gestation).

☐23. Homelessness.

☐24. Alcohol abuse by client.

☐25. Alcohol abuse by partner.

☐26. Drug dependence or misuse by client.

☐27. Drug dependence or misuse by partner.

☐28. Physical or emotional abuse/neglect of client.

☐29. Physical abuse of children in the home.

☐30. Neglect of children in the home.

☐31. Partner with history of violence.

☐32. Chronic or recent mental illness and/or psychiatric treatment.

☐33. Elevated blood lead level 15ug/dl or greater.

☐34. Other, identify: _____

_____

☐99. None of the above.

FOLLOWING DOES NOT QUALIFY FOR CASE MANAGEMENT SERVICES. DATA COLLECTION IS NECESSARY FOR PROGRAM PLANNING. (CHECK ONE)

☐ 1. Intended pregnancy.
☐ 2. Unintended pregnancy using birth control
☐ 3. Unintended pregnancy not using birth control.
☐ 4. Unintended pregnancy - birth control unknown.

SPECIFY GESTATIONAL AGE AT TIME OF RISK APPRAISAL: WEEKS	APPROXIMATE DUE DATE MM DD YY	PHYSICIAN'S PERFORMING PROVIDER NUMBER
PROVIDER SIGNATURE ▶		DATE
PREFERRED CASE MANAGEMENT PROVIDER AGENCY		

MO 580-1171 (9-97) **DISTRIBUTION:** **WHITE/CANARY** - BSHCN/CASE MANAGEMENT AT TIME OF ENTRY **GREEN** - CLIENT **PINK** - CLIENT'S RECORD CM-4

MISSOURI MEDICAID
CERTIFICATE OF MEDICAL NECESSITY

	Patient Name			Medicaid ID Number	
	TOS	Procedure Codes (Maximum 6)	Description of Item/Service	Reason for Service	Months Equip. Needed (DME only):
1.					
2.					
3.					
4.					
5.					
6.					

Attending/Prescribing Physician Name		Attending/Prescribing Physician Medicaid Number
Date Prescribed	Diagnosis	Prognosis
Provider Name and Address		Provider Medicaid Number
Provider Signature		

MO-8813 PLEASE SUBMIT THIS FORM FOR EACH PROCEDURE REQUIRING DOCUMENTATION OF MEDICAL NECESSITY DS1960 (09/01/02)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
EXCEPTIONS UNIT

MEDICAID EXCEPTION REQUEST

RETURN TO: ATTN EXCEPTIONS UNIT
DIVISION OF MEDICAL SERVICES
PO BOX 6500
JEFFERSON CITY MO 65102-6500
FAX NO: 573-522-3061

ALL INFORMATION MUST BE SUPPLIED OR THE REQUEST WILL BE RETURNED

FOR LIFE THREATENING EMERGENCIES
CALL 1-800-392-8030

PLEASE TYPE OR PRINT

RECIPIENT NAME	DATE OF BIRTH

RECIPIENT MEDICAID NUMBER (DCN)	SOCIAL SECURITY NUMBER

RECIPIENT DIAGNOSES (MUST RELATE TO ITEM(S) OR SERVICE(S) REQUESTED)

LIST ALL APPROPRIATE ALTERNATIVE COVERED SERVICES ATTEMPTED AND FOUND INEFFECTIVE FOR THIS DIAGNOSIS.

REQUESTED ITEM(S) OR SERVICE(S) (INCLUDING DAILY QUANTITY)

DURATION OF NEED

MISSOURI MEDICAID PROVIDER WHO WILL BE DISPENSING AND BILLING FOR SERVICES (EX. DME PROVIDER)

NAME	TELEPHONE NUMBER
ADDRESS	PROVIDER NUMBER (IF KNOWN)
IS A HOME HEALTH AGENCY MAKING SKILLED NURSE VISITS? ☐ YES ☐ NO	AGENCY NAME
PRINT OR TYPE DOCTOR'S NAME OR ADVANCED PRACTICE NURSE'S (APN) NAME AND TITLE	TELEPHONE NUMBER
PRINT OR TYPE DOCTOR'S ADDRESS OR APN'S ADDRESS	FAX NUMBER
DOCTOR'S ORIGINAL SIGNATURE, OR APN'S ORIGINAL SIGNATURE AND TITLE (NO STAMPS OR PHOTOCOPIES) ▶	DATE

MO 886-3351 (3-02)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

MISSOURI MEDICAID INSURANCE RESOURCE REPORT

TPL-4

Submit this form to notify the Medicaid agency of insurance information that you have verified for a Medicaid recipient. Please send the completed form to:

Department of Social Services
Division of Medical Services
Attention: TPL Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

DO **NOT** SEND CLAIMS WITH THIS FORM. YOUR CLAIM WILL **NOT** BE PROCESSED FOR PAYMENT IF ATTACHED TO THIS FORM.

PROVIDER IDENTIFICATION NUMBER	DATE (MM / DD / YY)
___ ___ ___ ___ ___ ___ ___ ___ ___	

PROVIDER NAME

CHECK THE APPROPRIATE BOX FOR THE REQUESTED ACTION

☐ ADD NEW RESOURCE OR ☐ CHANGE MEDICAID RESOURCE FILES

RECIPIENT NAME	MEDICAID I.D. NUMBER
	___ ___ ___ ___ ___ ___ ___ ___

INSURANCE COMPANY NAME

POLICYHOLDER (IF OTHER THAN RECIPIENT)	POLICYHOLDER'S SOCIAL SECURITY NUMBER

POLICY NUMBER	GROUP NAME OR NUMBER

VERIFIED INFORMATION

_____

_____

SOURCE OF VERIFIED INFORMATION: ☐ EMPLOYER ☐ INSURANCE COMPANY

TELEPHONE NUMBER OF CONTACT	DATE CONTACTED (MM / DD / YY)
( )	

NAME OF PERSON COMPLETING THIS FORM	TELEPHONE NUMBER

Do you want confirmation of this add/update?
(If yes, you **must** complete the name and address on back) ☐ YES ☐ NO

ATTACH A COPY OF AN EXPLANATION OF BENEFITS OR INSURANCE LETTER IF AVAILABLE

MO 886-2983 (2-97)

TO BE COMPLETED BY THE PROVIDER

If confirmation of this add/update is requested, please write the name and address of the person the confirmation should be sent to below. The TPL Unit will complete the bottom portion of this form and mail to the address shown.

_____

_____

_____

TO BE COMPLETED BY THE STATE

❑ Verification and correction as requested completed Date: _____

Insurance Begin Date: _____ Insurance End Date: _____

❑ Please resubmit claims

❑ Form not complete enough for verification by state - complete highlighted areas and resubmit

❑ TPL file already reflects the add/update. Our records were updated: _____

❑ Verification confirms Medicaid resource file correct as is - no update performed

❑ Change requested cannot be made. Reason:

_____

_____

_____

❑ Verification shows another current coverage that may be applicable:

_____

_____

_____

❑ Other: _____

_____

_____

_____

MO 886-2983 (2-97)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
PRIOR AUTHORIZATION REQUEST

Return to: Infocrossing Healthcare Services, Inc.
PO Box 5700
Jefferson City, MO 65102

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid Eligible on the date of service or date the equipment or prosthesis is received by the recipient. **SEE REVERSE SIDE FOR INSTRUCTIONS.**

I. GENERAL INFORMATION

1.	2. NAME (LAST, FIRST, M.I.)	3. DATE OF BIRTH
4. ADDRESS (STREET, CITY, STATE, ZIP CODE)		5. MEDICAID NUMBER
6. PROGNOSIS	7. DIAGNOSIS CODE	8. DIAGNOSIS DESCRIPTION
9. NAME & ADDRESS OF FACILITY WHERE SERVICES ARE TO BE RENDERED IF OTHER THAN HOME OR OFFICE.		

II. HCY (EPSDT) SERVICE REQUEST (MAY REQUIRE PLAN OF CARE)

10. DATE OF HCY SCREEN	11. SCREENING ☐ FULL ☐ INTERPERIODIC ☐ PARTIAL	12. TYPE OF PARTIAL HCY SCREEN
13. SCREENING PROVIDER NAME	14. PROVIDER NUMBER	15. TELEPHONE NUMBER ( )

III. SERVICE INFORMATION

16. REF. NO.	17. PROCEDURE CODE	18. MODIFIERS	19. FROM	20. THROUGH	21. DESCRIPTION OF SERVICE/ITEM	22. QTY. OR UNITS	23. AMOUNT TO BE CHARGED	FOR STATE USE ONLY APPR.	DENIED	AMOUNT ALLOWED IF PRICED BY REPORT
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										
(8)										
(9)										
(10)										
(11)										
(12)										

24. DETAILED EXPLANATION OF MEDICAL NECESSITY FOR SERVICES/EQUIPMENT/PROCEDURE/PROSTHESIS (ATTACH ADDITIONAL PAGES IF NECESSARY)

IV. PROVIDER

25. PROVIDER NAME (AFFIX LABEL HERE)

26. ADDRESS

27. MEDICAID PROVIDER NUMBER

28. SIGNATURE | DATE

V. PRESCRIBING/PERFORMING PRACTITIONER

29. NAME | 30. TELEPHONE ( )

31. ADDRESS

32. DATE DISABILITY BEGAN | 33. PERIOD OF MEDICAL NEED IN MONTHS

I certify that the information given in Sections I and III of this form is true, accurate, and complete.

34. SIGNATURE OF **PRESCRIBING PHYSICIAN/PRACTITIONER** | DATE

VI. FOR STATE OFFICE USE ONLY

DENIAL REASON(S): REFER TO FIELD 16 ABOVE BY REFERENCE NUMBERS (REF. NO.)

IF APPROVED: services authorized to begin | DATE | REVIEWED BY SIGNATURE ▶

MO 886-0858 (11-04) MO 880

INSTRUCTIONS FOR COMPLETION

I. GENERAL INFORMATION – To be completed by the provider requesting the prior authorization.

1. Leave Blank
2. Recipient's Name – Enter the recipient's name as it appears on the Medicaid ID card. Enter the recipient's current address.
3. Date of Birth – Enter the recipient's date of birth.
4. Address – Enter the recipient's address, city, state, and zip.
5. Medicaid Number – Enter the recipient's 8-digit Medicaid identification number as shown on the Medicaid identification card or county letter of eligibility.
6. Prognosis – Enter the recipient's prognosis.
7. Diagnosis Code – Enter the diagnosis code(s).
8. Diagnosis Description – Enter the diagnosis description. If there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
9. Name and address of the facility where services are to be rendered if service is to be provided other than home or office.

II. HCY SERVICE REQUEST (Plan of care may be required, see your provider manual)

10. Date of HCY Screen – Enter the date the HCY Screen was done.
11. Screening – Check whether the screening performed was FULL, INTERPERIODIC, or PARTIAL.
12. Type of Partial HCY Screen – Enter the type of partial HCY Screen that was performed. (e.g., Vision, Hearing, etc.)
13. Screening Provider Name – Enter the provider's name who performed the screening.
14. Provider Number – Enter the provider's number who performed the screening.
15. Telephone Number – Enter the screening provider's telephone number including the area code.

III. SERVICE INFORMATION

16. Ref. No. = (Reference Number) A unique designator (1-12) identifying each separate line on the request.
17. Procedure Code – Enter the procedure code(s) for the services being requested.
18. Modifier – Enter the appropriate modifier(s) for the services being requested.
19. From – Enter the from date that services will begin if authorization is approved (mm/dd/yy format).
20. Through – Enter the through date the services will terminate if authorization is approved (mm/dd/yy format).
21. Description of Service/Item – Enter the specific description of the service/item being requested.
22. Quantity or Units – Enter the quantity or units of service/item being requested.
23. Amount to be Charged – Enter the amount to be charged for the service.
24. Detailed Explanation of Medical Necessity of the service, equipment/procedure/prosthesis, etc. Attach additional page(s) as necessary. **Do not use another Prior Authorization Form.**

IV. PROVIDER REQUESTING PRIOR AUTHORIZATION

25. Provider Name – Attach a Medicaid provider label or enter the requested provider's information exactly as it appears on the label.
26. Address – If a Medicaid provider label is not used, enter the complete mailing address in this field.
27. Medicaid Provider Number – If a Medicaid provider label is not used, enter the provider's Medicaid identification number.
28. Signature/Date – The provider of services should sign the request and indicate the date the form was completed. (Check your provider manual to determine if this field is required.)

V. PRESCRIBING/PERFORMING PRACTITIONER

This section must be completed for services which require a prescription such as Durable Medical Equipment, Physical Therapy, or for services which will be prescribed by a physician/practitioner that require Prior Authorization. Check your provider manual for additional instructions.

29. Name – Enter the name of the prescribing/performing/practitioner.
30. Telephone Number – Enter the prescribing/performing/practitioner telephone number including area code.
31. Address – Enter the address, city, state, and zip code.
32. Date Disability Began – Enter the date the disability began. For example, if a disability originated at birth, enter date of birth.
33. Period of Medical Need in Months – Enter the estimated number of months the recipient will need the equipment/services.
34. Signature of prescribing/performing/practitioner – The prescribing physician/practitioner must sign and indicate the date signed in mm/dd/yy format. **(Signature stamps are not acceptable)**

VI. FOR STATE OFFICE USE ONLY

Approval or denial for each line will be indicated in the box to the right of Section III. Also in this box the consultant will indicate allowed amount if procedure requires manual pricing.

At the bottom, the consultant may explain denials or make notations referencing the specific procedure code and description by number (1 thru 12). The consultant will sign or initial the form.

DS1926

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

MISSOURI MEDICAID ACCIDENT REPORT

Submit this form to notify the Medicaid agency of information you have regarding a Medicaid recipient's accident or injury. Please send the completed form to:

Department of Social Services
Divison of Medical Services
Attention: TPL Casualty/Tort Recovery
P.O. Box 6500
Jefferson City, Missouri 65102-6500

DO NOT send claims with this form. Your claims will not be processed for payment if attached to this form.

PROVIDER IDENTIFICATION NUMBER	DATE (MM/DD/YY)
PROVIDER NAME	DATES OF SERVICE
RECIPIENT NAME	MEDICAID NUMBER
DATE OF ACCIDENT/INJURY	APPROXIMATE TIME

TYPE OF ACCIDENT/INJURY

☐ AUTO ☐ WORK-RELATED ☐ OTHER (EXPLAIN)

ATTORNEY REPRESENTING RECIPIENT

RESPONSIBLE PARTY'S NAME	POLICY/CLAIM NUMBER

INSURANCE COMPANY NAME AND ADDRESS

HAVE YOU FILED A LIEN? IF YES, PLEASE PROVIDE DETAILS (I.E., AMOUNT, SERVICE DATES, ETC.)

☐ YES ☐ NO

REMARKS

Please attach copies of relevant documents (i.e. letters from attorneys, insurance companies, etc.) if applicable.

THANK YOU FOR YOUR ASSISTANCE.

MO 886-3016 (3-93) TPL-2P

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

APPLICATION FOR PROVIDER DIRECT DEPOSIT

PLEASE TYPE OR PRINT IN BLACK INK ******SEE INSTRUCTIONS ON REVERSE SIDE******

SECTION A (All providers must complete this section)

1.TYPE OF DIRECT DEPOSIT ACTION➨ □ New provider/Re-enrollment ✦□ Cancel Direct Deposit ✦□ Change Account/Route number

2.PROVIDER NAME: Complete provider name below as shown on provider labels. **If the Application for Provider Direct Deposit is for a clinic or group,** this form must be accompanied by an Authorization by Clinic Members which **must** contain a list of the provider name(s) and number(s) of all Advanced Practice Nurses, CRNA's, Physicians, and Diabetes Self-Management Training providers employed at that clinic/group, along with the **ORIGINAL** signature of the clinic owner or administrator. All other providers **MUST** complete a **separate** Application for Provider Direct Deposit containing their individual provider number and ***original*** signature. The clinic Application for Provider Direct Deposit will not be processed without the completed Authorization by Clinic Members. **A separate Application for Provider Direct Deposit must be completed for each provider number assigned.**

TYPE OR PRINT PROVIDER NAME HERE ➨

3.PROVIDER NUMBER (enter provider number as shown on provider label, **one provider number per application**)

____ ____ ____ ____ ____ ____ ____ ____ ____

SECTION B (Complete this section if you wish to enroll in direct deposit OR a change in account/route number(s) is requested.)

(ATTACH a voided check showing the routing/account numbers, OR if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution completed below. The information completed on this form and the information on the attachment MUST match.

1. ROUTING NUMBER	2. DEPOSITOR ACCOUNT NUMBER
_____	_____

3. TYPE OF ACCOUNT (***must check one***) ➨ □ CHECKING ✦ □ SAVINGS

4. FINANCIAL INSTITUTION NAME	5. BRANCH NUMBER OR NAME (if applicable)
6. FINANCIAL INSTITUTION ADDRESS	7. TELEPHONE NUMBER (include area code)

SECTION C

I wish to participate in Direct Deposit and in doing so:

- ✦ I understand that in endorsing or depositing checks that payment will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State laws.
- ✦ I hereby authorize the State of Missouri to initiate credit entries (deposits) and to initiate, if necessary, debit entries (withdrawals) or adjustments for any **credit entries made in error** to my account designated above.
- ✦ I understand that the State of Missouri may terminate my enrollment in the Direct Deposit program if the State is legally obligated to withhold part or all payments for any reason.
- ✦ I understand that the Division of Medical Services may terminate my enrollment if I no longer meet the eligibility requirements.
- ✦ I understand that this document shall not constitute an amendment or assignment, of any nature whatsoever, of any contract, purchase order or obligation that I may have with an agency of the State of Missouri.

I am authorized to request Direct Deposit on behalf of this clinic/group and in doing so:

- ✦ I acknowledge that each individual in the clinic/group listed on the attached Authorization by Clinic Members has been informed of this request, and also informed that Medicaid funds will be sent to the depositor account specified above.
- ✦ I understand that each individual provider is responsible for all services provided and all billing done under the individual or clinic provider number, regardless to whom the reimbursement is paid. It is each individual provider's responsibility to use the proper billing code and indicate the length of time actually spent providing a service, regardless to whom the reimbursement is paid.

1. ❑ **I HEREBY CANCEL MY DIRECT DEPOSIT AUTHORIZATION** and authorize future payments to be sent to the current payment name and address recorded in the provider enrollment file. ***(Section A number 1 must also be completed)***

2. PROVIDER *ORIGINAL* SIGNATURE (*see requirements on reverse side of this form*)	TYPE OR PRINT NAME SIGNED & TITLE	3.DATE	4.TELEPHONE NUMBER

RETURN ORIGINAL FORM (and original Authorization by Clinic Members, if applicable) ***ALONG WITH A VOIDED CHECK OR LETTER FROM YOUR BANK (see Section B) TO:*** Division of Medical Services, Provider Enrollment Unit, PO Box 6500, Jefferson City MO 65102. Phone 573-751-2617

THIS FORM CANNOT BE FAXED

MO 886-3089 (3-2000) Page 1

APPLICATION FOR PROVIDER DIRECT DEPOSIT INSTRUCTIONS

SECTION A ***ALL providers must complete this section***

1. **Type of Direct Deposit Action** -Check appropriate box. **If canceling direct deposit you must also complete Section C, #1.**
2. & 3. **Provider Name and Provider Number** - Enter provider name **and** number **EXACTLY** as shown on your provider label.

SECTION B ***This section must be complete for new applicants or re-enrollments and any changes to your direct deposit information.

ATTACH a voided check showing the routing/account numbers, **OR** if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution **to the back of this form.** The information completed on this form and the information on the attachment **MUST** match.

1. **Routing Number** - Enter your financial institution's routing number as printed on the bottom left portion of your business checks or deposit tickets (the first 9 digits). See Examples 1 and 2 below.
2. **Depositor Account Number** - Enter depositor account number as printed on the bottom of business checks following the routing number. It may be the first series of digits after the routing number followed by your check number (example 1) or it may be the series of digits which follow your check number (example 2). NOTE: The check number is not included in the depositor account number.

EXAMPLE 1

FINANCIAL INSTITUTION CHECK NO.4444
HOMETOWN, USA

PAY TO ORDER OF _____

121456789 8765432109812 4444

↕ Routing No. ↕ Depositor Acct No. ↕ Check No.

EXAMPLE 2

FINANCIAL INSTITUTION CHECK 4444
HOMETOWN, USA

PAY TO ORDER OF _____

121456789 4444 8765432109812

↕ Routing No. ↕ Check No. ↕ Depositor Acct No.

*********Credit Unions and Savings and Loan Associations may differ from the above examples. Please VERIFY your DEPOSITOR ACCOUNT NUMBER and ELECTRONIC ROUTING NUMBER with your financial institution.*********

SECTION C

1. **TO CANCEL OR REDESIGNATE:** Complete and submit a new Application for Provider Direct Deposit with the changed information and forward to the Division of Medical Services. **You must check the *CANCEL* box if you wish to *CANCEL* your direct deposit, Section A number 1 must also be completed.** If you elect to cancel direct deposit future payments will be sent to the current payment name and address recorded in the provider enrollment file. Provider direct deposits will continue to be deposited into the designated account at your financial institution until the Division of Medical Services is notified that you wish to ***cancel or redesignate*** your account and/or financial institution.
   DO NOT CLOSE AN OLD ACCOUNT UNTIL THE FIRST PAYMENT IS DEPOSITED INTO YOUR NEW ACCOUNT.
2. **PROVIDER SIGNATURE** - If the provider is enrolled as an individual, he/she must sign the form. Nursing homes, hospitals, independent laboratories and home health agencies must be signed by a person listed on form HCFA-1513 (disclosure of ownership) section III (a). If enrolled as a clinic or business (except those listed above) the form must be signed by the person with fiscal responsibility for the same. **Clinic applications must be accompanied by the Authorization by Clinic Members which must contain** a list of the name(s) and provider number(s) of all Advanced Practice Nurses, CRNA's, Physicians, and Diabetes Self-Management Training providers employed at that clinic location. **The Application for Provider Direct Deposit and the Authorization by Clinic Members MUST be signed by the same person. All other providers must complete** a separate Application for Provider Direct Deposit containing their individual provider number and **original** signature. **A SEPARATE FORM MUST BE COMPLETED FOR EACH PROVIDER NUMBER ASSIGNED.**

OTHER

1. **ATTACH** a voided check showing the routing/account numbers, **OR** if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution **to the back of this form.** The information completed on this form and the information on the attachment **MUST** match.
2. Direct deposit will be initiated after a properly completed application form is approved by the Division of Medical Services and the successful processing of a test transaction through the banking system.
3. **This form must be used to change** any financial institution information **or to cancel** your election to participate in direct deposit.
4. The Division of Medical Services will terminate or suspend the direct deposit option for administrative or legal actions including, but not limited to, ownership change, duly executed liens or levies, legal judgements, notice of bankruptcy, administrative sanctions for the purpose of ensuring program compliance, death of a provider and closure or abandonment of an account.
5. If any information completed on this form cannot be verified from the attachments or the form is completed incorrectly, the form(s) will be returned without being processed for direct deposit.

MO 886-3089 (3-2000) Page 2

MISSOURI MEDICAID
SECOND SURGICAL OPINION FORM

PLEASE PRINT OR TYPE

SECTION I: TO BE COMPLETED BY PRIMARY (FIRST OPINION) PHYSICIAN — MO-8807

RECIPIENT'S NAME (FIRST) (M.I.) (LAST)				RECIPIENT'S MEDICAID I.D. NUMBER	
SURGICAL PROCEDURE DISCUSSED & RECOMMENDED			CPT-4 PROCEDURE CODES		ICD-9-CM DX. CODE
PERTINENT HISTORY SYMPTOMS AND PHYSICAL FINDINGS					
PHYSICIAN'S NAME (FIRST) (MI) (LAST)				Physician's Mo. Medicaid Provider No.	
PHYSICIAN'S OFFICE ADDRESS (Street) (City) (State) (Zip Code)				SPECIALITY, IF APPLICABLE	
APPOINTMENT DATE	PERSONAL SIGNATURE OF PRIMARY PHYSICIAN (NAME)			(DATE)	

REFER THIS FORM TO THE SECOND OPINION PHYSICIAN WITH RESULTS OF PATIENT'S HISTORY AND PHYSICAL REPORT, LABORATORY DATA, X-RAYS, ETC. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION II: TO BE COMPLETED BY SECOND SURGICAL OPINION PHYSICIAN

NEED FOR SURGERY ☐ CONFIRMED ☐ NOT CONFIRMED	STATE REMARKS:			
SURGICAL PROCEDURE RECOMMENDED. IF SURGERY CONFIRMED			CPT-4 PROCEDURE CODES	ICD-9-CM DX. CODE
SECOND OPINION PHYSICIAN'S NAME (FIRST) (M.I.) (LAST)				Physician's Mo. Medicaid Provider No.
SECOND OPINION PHYSICIAN'S OFFICE ADDRESS (Street) (City) (State) (Zip Code)				SPECIALITY, IF APPLICABLE
APPOINTMENT DATE	PERSONAL SIGNATURE OF SECOND OPINION PHYSICIAN (NAME)			(DATE)

REFER THIS FORM BACK TO THE PRIMARY (FIRST OPINION) PHYSICIAN REFERENCED IN SECTION I. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION III: TO BE COMPLETED BY THIRD SURGICAL OPINION PHYSICIAN

(A third surgical opinion is covered by Mo. Medicaid only if the second surgical opinion physician did not recommend surgery)

NEED FOR SURGERY ☐ CONFIRMED ☐ NOT CONFIRMED	STATE REMARKS:			
SURGICAL PROCEDURE RECOMMENDED, IF SURGERY CONFIRMED			CPT-4 PROCEDURE CODES	ICD-9-CM DX. CODE
THIRD OPINION PHYSICIAN'S NAME (FIRST) (M.I.) (LAST)				Physician's Mo. Medicaid Provider No.
THIRD OPINION PHYSICIAN'S OFFICE ADDRESS (Street) (City) (State) (Zip Code)				SPECIALITY, IF APPLICABLE
APPOINTMENT DATE	PERSONAL SIGNATURE OF THIRD OPINION PHYSICIAN (NAME)			(DATE)

REFER THIS FORM BACK TO THE PRIMARY (FIRST OPINION) PHYSICIAN REFERENCED IN SECTION I. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION IV: TO BE COMPLETED BY SURGEON, IF SURGERY IS PERFORMED AT REQUEST OF RECIPIENT

SURGICAL PROCEDURE PERFORMED				CPT-4 PROCEDURE CODES
ICD-9-CM DX. CODE	SPECIFY NAME AND ADDRESS OF SURGERY SITE			
DATE OF SURGERY				
SURGEON'S NAME (FIRST) (M.I.) (LAST)				Physician's Mo. Medicaid Provider No.
SURGEON'S OFFICE ADDRESS (Street) (City) (State) (Zip Code)				SPECIALITY, IF APPLICABLE
PERSONAL SIGNATURE OF SURGEON (NAME)				(DATE)

THE SURGEON MUST ATTACH THIS COMPLETED SECOND SURGICAL OPINION FORM TO HIS MEDICAID CLAIM FOR THE SURGICAL PROCEDURE. IT IS THE SURGEON'S RESPONSIBILITY TO FURNISH A COPY OF THIS COMPLETED FORM TO THE HOSPITAL/ AMBULATORY SURGICAL CARE CENTER, IN ORDER THAT THE FACILITY MAY BILL MEDICAID FOR RELATED CHARGES. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS.

DS1907 (02/01)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

This form must be completed when a hysterectomy is to be performed which is not precluded from Medicaid reimbursement under Federal regulatory provisions at 42 CFR 441.255(a) and which is not exempted from the requirement for this documentation under provisions at 42 CFR 441.255(d) or (e).

The requirement for Acknowledgement of Receipt of Hysterectomy Information applies to an individual of any age. The form must be signed by the recipient or her representative, if any, prior to the surgery. Hysterectomies for family planning purposes are not payable through Medicaid or any other federally funded program, nor from the general relief or blind pension programs.

1. NAME OF RECIPIENT	2. MEDICAID ID NUMBER	3. NAME OF REPRESENTATIVE

1. SOURCE OF HYSTERECTOMY INFORMATION

PART I
TO BE COMPLETED BY THE PERSON WHO SECURES THE AUTHORIZATION TO PERFORM THE HYSTERECTOMY

5. I certify that I have informed the above named recipient and her representative, if any, **orally and in writing,** that the hysterectomy will render her permanently incapable of reproducing. I further certify that the purpose for performing the hysterectomy is:

6. SIGNATURE AND TITLE OF PERSON SECURING AUTHORIZATION	7. DATE (MONTH/DAY/YEAR)

8. PHYSICIAN / CLINIC NAME	9. PROVIDER MEDICAID NUMBER
▶	

PART II COMPLETE A OR B

If B is completed, the reason the recipient is incapable of signing must be stated on the line provided in Item B. (B is not to be completed if the recipient is capable of signing in Item A.)

A. TO BE COMPLETED BY THE RECIPIENT RECEIVING THE HYSTERECTOMY PRIOR TO THE OPERATION

I have received, **orally and in writing,** information from the above named source, stating that the hysterectomy will render me permanently incapable of reproducing. I understand that I will not be able to become pregnant or bear children.

10. SIGNATURE OF RECIPIENT	11. DATE (MONTH/DAY/YEAR)
▶	

B. TO BE COMPLETED BY A REPRESENTATIVE OF THE RECIPIENT RECEIVING THE HYSTERECTOMY

I, the representative named above, certify that the designated recipient accepts and understands that I am her representative and that she has received, **orally and in writing,** information from the above named source, stating that the hysterectomy will render her permanently incapable of reproducing. She understands that she will not be able to become pregnant or bear children.

12. REASON RECIPIENT INCAPABLE OF SIGNING

13. SIGNATURE OF REPRESENTATIVE	14. RELATIONSHIP TO RECIPIENT	15. DATE (MONTH/DAY/YEAR)
▶		

MO 886-3280 (11/01/00)

Forms Request

Provider Number: _____ Date: _____
(Or Affix Provider Label Here)

Provider Name: _____

Provider Phone: _____

CLAIM FORMS	Quantity Preprinted	Quantity Blank
A. Pharmacy		
B. Dental		
C. HCFA 1500 (Rev 12/90)		
D. HCFA 1450 (UB-92) Inpatient / Outpatient/ Home Health		
F. Prior Authorization		

CROSSOVER STICKERS

G. Hospital Crossover Sticker (BLACK)	
H. SNF Crossover Sticker (RED)	
I. Part B Crossover Sticker (BLUE)	

If provider labels are needed with blank Claim Forms (A-F), check box. ☐

If you checked box, an equal number of labels will be supplied with Forms A-F. If you DID NOT check box, you WILL NOT receive labels.

If provider labels are needed and you are not ordering Forms A-F, indicate the quantity _____

SPECIAL MAILING INSTRUCTIONS:

Name: _____

Attn: _____

Street Address: _____

_____
(Not P.O. Box)

City: _____

State: _____ Zip: _____

ADDRESS CHANGE / CORRECTION:

Provider Number: _____

Name: _____

Street Address: _____

_____
(Not P.O. Box)

City: _____

State: _____ Zip: _____

Effective Date of Change: _____

ATTACHMENTS	Quantity
J. HCY Medical Screening Tool (All Pages)	
HCY Screening Forms by Age Group	
2. Newborn - 1 month/2 - 3 months	
3. 4 - 5 months/6 - 8 months	
4. 9 - 11 months/12 - 14 months	
5. 15 - 17 months/18 - 23 months	
6. 24 months/3 years	
7. 4 years/5 years	
8. 6 - 7 years/8 - 9 years	
9. 10 - 11 years/12 - 13 years	
*. 14 - 15 years/16 - 17 years	
&. 18 - 19 years/20 years	
K. HCY Lead Risk Assessment Guide	
L. Sterilization Consent	
M. Acknowledge Hysterectomy	
O. Hearing Aid Evaluation	
P. Medical Necessity	
Q. Adjustment Request	
R. Medical Necessity Long Term HPN	
S. Second Surgical Opinion	
T. Medical Necessity - Abortion	
U. Hospice Election Statement	
V. Oxygen - Respiratory Justification	
W. Notification of Termination of Hospice Benefits	
Y. Insurance Resource Report (TPL-4)	
Z. Accident Reporting Form (TPL-2P)	
1. Physician Certification of Terminal Illness	

_____
* Provider Signature: (Must Be Provider's Original Signature)

All requests are delivered to the address on your current provider label unless an address change or correction is requested above. An address change or correction changes your provider billing label. If Special Mailing Instructions are indicated, this and all future requests for forms from Verizon Data Services are delivered to this address until notice of a change is received. A change to Special Mailing Instructions does not change your provider billing label.

The above forms are provided to all participating Missouri Medicaid Providers. They are intended solely for Missouri Medicaid claims filing. Please complete the above information and return it to Verizon Data Services via any paper claims submission P.O. Box. For information regarding electronic claims submission, contact Verizon Data Services at (573) 635-3559.

DS1054 (Rev. 11/00)

Nondiscrimination Policy Statement

The Missouri Department of Social Services (DSS) is committed to the principles of equal employment opportunity and equal access to services. Accordingly, DSS shall take affirmative action to ensure that employees, applicants for employment, clients, potential clients, and contractors are treated equitably regardless of race, color, national origin, sex, age, disability, religion, or veteran status.

All DSS contracts and vendor agreements shall contain non-discrimination clauses as mandated by the Governor's Executive Order 94-3, Article XIII. Such clauses shall also contain assurances of compliance with Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended/ the Americans with Disabilities Act of 1990 (ADA), as amended; the Age Discrimination Act of 1975, as amended and other pertinent civil rights laws and regulations.

Applicants for, or recipients of services from DSS who believe they have been denied a service or benefit because of race, color, national origin, sex, age, disability or religion may file a complaint by calling the DSS Office for Civil Rights at 1-800-776-8014. Complaints may also be filed by contacting the local office or by writing to:

Missouri Department of Social Services
Office for Civil Rights
P. O. Box 1527
Jefferson City, MO 65102-1527

or

U.S. Department of Health and Human Services
Office for Civil Rights
601 East 12th Street
Kansas City, MO 64106

Additionally, any person who believes they have been discriminated against in any United States Department of Agriculture related activity (e.g. food stamps, commodity food, etc.) may write to the United States Department of Agriculture at:

USDA Office of Civil Rights
1400 Independence Ave., SW
Mail Stop 9410
Washington, DC 20250